

GRADUATE MANAGEMENT PROJECT

Case Study:

**The Implementation of
Multi-Specialty Primary Care Clinics at
Colonel Florence A. Blanchfield Army Community Hospital**

Presented to

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**U.S. Army-Baylor University
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by

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ABSTRACT

Blanchfield Army Community Hospital provides health care services to approximately 73,000 beneficiaries within the Fort Campbell health services area, averaging nearly 750,000 outpatient visits per year. In an effort to enhance the access, accountability, and efficiency of BACH's primary health care delivery system, BACH made a revolutionary change in the way it delivers primary care services. It consolidated the traditional single specialty outpatient clinics of Family Practice, Obstetric and Gynecology, and Pediatrics into three multi-specialty primary care clinics (PCC).

Because the PCC is a new entrant in military health care delivery systems, this offered a unique opportunity to analyze the conversion to primary care clinics, study the problems that were encountered, develop an implementation blueprint, and make recommendations for improvements.

By employing the descriptive case study method of analysis, an implementation blueprint for a multi-specialty primary care clinic was developed and is presented in Appendix A. Appendix A, a stand alone document, provides general project information, a directed narrative, staffing levels by specialty, required equipment, an implementation schedule, and a post-opening evaluation plan. Additionally, opportunities for improvement during BACH's PCCs implementation are cited in the discussion

chapter.

This study may have broad implications for the future of military medicine. Because increased emphasis is being placed on primary care as a means to enhance access, reduce costs, and maintain quality care; it is very possible other military clinics similar to the PCCs will be established in the near future. Thus, this completed analysis provides valuable information and serves as a model for other military health care administrators to follow when converting to multi-specialty primary care clinics.

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CASE STUDY:
THE IMPLEMENTATION OF
MULTI-SPECIALTY PRIMARY CARE CLINICS AT
COLONEL FLORENCE A. BLANCHFIELD ARMY COMMUNITY HOSPITAL

INTRODUCTION

Conditions Which Prompted The Study

Colonel Florence A. Blanchfield Army Community Hospital, commonly known as BACH, made a revolutionary change in the way it delivers primary care services. BACH consolidated the traditional single specialty outpatient clinics of Family Practice, Obstetric and Gynecology, and Pediatrics into three multi-specialty primary care clinics (PCC). Because the PCC is a new entrant in military health care delivery systems, there is little research, literature, or experience concerning its implementation. Thus, the BACH staff should have: researched the requirements, derived an implementation plan, and then managed the plan's execution. This offered a unique opportunity to analyze the conversion to primary care clinics, study the problems that were encountered, and make recommendations for improvements. For the purpose of this study, primary care services are defined as those services rendered to patients with common problems or complaints, usually the patient's first contact with the healthcare system for a particular episode of

illness. Primary care usually includes disease prevention, health promotion, and linkage among medical services.

Overview

In recent years, the combined effects of economic, political, and societal factors have resulted in the practice of medicine becoming the object of close public scrutiny and have, ultimately, provided the catalyst for this study. Since the inception of Medicare in 1965, the nation's medical care cost have skyrocketed, outpacing other inflationary increases by double digits. Subsequently, numerous plans have been devised and efforts made to reduce the enormity of medical costs increases. Numerous notable medical experts such as Ira Magaziner, government officials like President Clinton, and laypersons such as Hillary Clinton, believe a healthcare industry that utilizes an innovative and aggressive primary care system will aid significantly in the slowing of medical costs increases.

In the late 1980s, Congress mandated the Department of Defense (DoD) to constrain the growth of military health care costs. In response, DoD developed a managed care system, commonly known as Coordinated Care. By 1991, the Army's Health Services Command (HSC) proposed a version of coordinated care, termed Gateway to Care. The tenets of Gateway to Care are aligned with the health care triad of access, quality, and cost. The tenets are to provide eligible beneficiaries improved access to the appropriate level of care at the lowest cost, while maintaining quality of the care. Additionally, the program's

intent is to recapture CHAMPUS dollars. A large portion of the Gateway to Care success is predicated on the use of the primary care provider as the gatekeeper of other medical services.

In a more recent effort to control medical costs while providing the military treatment facility (MTF) commander with maximum operational and budgetary flexibility, DoD has delegated budgetary control down to the MTF commander via capitation budgeting and MTF business plans. While capitation budgeting forces the MTF commander to seek cost efficient provision of medical services, the business plan affords flexibility by allowing the MTF commander to design the care delivery system. When designing the business plan, MTF commanders must consider numerous factors such as beneficiary population, MTF mission, budget, staffing, services provided, installation mission, and availability of local area (off-post) medical care.

Colonel Florence A. Blanchfield Community Army Hospital

Colonel Florence A. Blanchfield Army Community Hospital's mission, according to their Table of Distribution and Allowances (TDA), is to provide health care services to authorized personnel within the Fort Campbell health services area, including inpatient and outpatient medical care and treatment to active and retired personnel, their family members, and other personnel as authorized by Department of the Army. The TDA, an Army organization and authorization document, provides hospital commanders with specific manning and equipment authorizations to perform the above stated mission.

Blanchfield Army Community Hospital's catchment area has approximately 72,948 beneficiaries. Population segmentation is shown in Table 1 (Jensen 1993).

TABLE 1

Blanchfield Army Community Hospital Beneficiaries	
Category	Population
Active Duty	22,726
Active Duty Dependents	32,938
Retirees	6,191
Retiree Dependents	9,800
Survivors	1,293

Prior to the implementation of the primary care clinics, dependent primary care services were provided by the family practice physicians, outpatient clinics or other various care providers within the hospital. Table 2 depicts increased utilization for the outpatient clinics and the emergency center over the past three years. Additionally, the enormous volume of primary care visits at BACH is shown in Table 3.

TABLE 2

CLINIC UTILIZATION TRENDS			
Type Visit	Year		
	1993	1992	1991
Outpatient	723,997	654,158	480,013
Emergency Center	59,141	55,704	46,228

TABLE 3

PRIMARY CARE UTILIZATION	
Clinic Visits - October 1992 through May 1993	
Clinic	Visits
Pediatrics	35,703
Family Practice	43,148
Gynecology	15,437
Obstetrics	12,138

Because of medical manpower constraints, only the 1st Bde, 2nd Bde, 3rd Bde, Aviation Bde, 5th Special Forces Group, 160th Aviation Regiment, MEDDAC, and DENTAC were enrolled in Family Practice. That left 19 major units without family practice enrollment. Unfortunately, this situation resulted in a sense of "the haves and the have nots", among beneficiaries. In an effort to resolve this dilemma, BACH's command staff decided to institute a PRIMUS clinic. In the fall of 1992, HSC denied funding for this project.

Primary Care Clinics Concept

During the past two years, events such as: HSC's denial of funding for the Fort Campbell Primary Care of the Uniformed Services (PRIMUS) clinic; a reduced capitated budget; reductions in hospital staff; rising health care costs; and increased demand for health services served as the catalysts for BACH's command staff to find innovative ways to manage medical care. The implementation of the Primary Care Clinics (PCC) was one such innovation. The intent of the PCCs is to enhance the access,

accountability, and efficiency of BACH's primary health care delivery system.

Blanchfield Army Community Hospital's primary care clinic concept was to consolidate the family practice outpatient clinic, pediatric outpatient clinic and some OB/GYN services into three PCCs (Red, White, and Blue). These three clinics were for the most part to be staffed by active duty providers. Each clinic was designed to have four family physicians, two pediatricians, a general medical officer, two physician assistants, two nurse practitioners, two telephone health care advice nurses (THCAN), and two decentralized appointment clerks.

In practice, active duty dependents are assigned to a specific clinic based upon the sponsor's military unit. An additional PCC, the Sterling Clinic, is operated for CHAMPUS eligible retirees and their dependents. This clinic is staffed by CHAMPUS partners. Under the PCC initiative, the rendering of all non-emergent care for enrollees is normally performed by the primary care provider (gatekeeper) at the PCC. Originally, active duty dependents, retirees, and their dependents enrollees were to agree to first seek health services at the PCC, but this provision has yet to be implemented because of congressional restrictions.

Two THCANs per clinic allow patients to telephonically seek medical advice from a registered nurse. In a recent study performed by BACH's Coordinated Care Division, it was determined that only 18% of 10,000 THCAN calls needed to seek further

medical care. Furthermore, it was estimated that the program reduced unwarranted patient visits by as many as 2,000 per month.

Implementation

As with any major undertaking, the proper implementation of this project was crucial to its success and how it was received by both the beneficiaries and the staff. Since this was a novel and significant change in the way military primary care is delivered, there was little historical data concerning the implementation of similar military clinics. So, this study was performed in an effort to provide insightful literature to other military medical facilities who may decide to take this course of action. The study analyzed BACH's implementation process, and because the PCC concept is relatively new to the MHSS it was important to research and document such a conversion with tools such as a case study.

Problem Statement

To develop a highly functional method of converting military single specialty outpatient clinics into multi-specialty primary care clinics. This will be accomplished by analyzing BACH's PCC conversion to include required tasks, logistical requirements, personnel requirements, problems encountered and opportunities for improvements.

Literature Review

Since Bill Clinton's election as President, healthcare reform has taken on renewed emphasis. As late as 4 January 1994,

the President's spokesperson stated that the passage of healthcare reform is the number one priority of the Clinton administration in 1994. This fact, in concert with economic and social pressures, is forcing healthcare delivery systems to undergo considerable changes, many of which are more oriented towards primary care.

In her article, Munn supports the idea of ongoing transformation of healthcare delivery systems by stating that the healthcare industry is in a constant state of evolution or refinement with changes in mission, philosophy, and delivery system. She states that one recent study shows 83.7% of responding healthcare organizations are planning either major changes in services or construction between 1992 and 1995. Such changes often require renovation and always require a detailed plan for implementation (Munn 1992).

In his article Ten Leadership Steps to a Smooth Facility Upgrade, Womack supports the idea that implementation planning is a requirement for success. He recommends that the need be identified, a project philosophy and working relationships be established, the implementation be planned, and the plan be executed.

Marketing - The Need

According to Klegon and Slubowki, marketing is a key consideration for any changes in healthcare services or initiatives such as primary care clinics. At the very start, it is imperative to clearly define the target population, scope of

services to be provided (product), the place, the price, and promotion. To perform required steps, they strongly recommend the use of an initial market assessment (Klegon 1985). In his article, Fritz agrees by recommending the hiring of an actuarial firm to define the population and design a computer-based model to assist in the marketing process (Fritz 1988). Once the target population is identified, Klegon and Slubowski recommend the use of focus groups to gather data for product development. After product development, a targeted promotional campaign, and an evaluation using tools such as a consumer survey need to be conducted (Klegon 1985).

Project Philosophy and Goals

Womack believes that of major importance to the success and acceptance of a project is the establishment of a project philosophy at the earliest possible date. The project philosophy acts as a decision making guide throughout the project (Womack 1992). As examples: " We will maintain a zero sum gain of personnel for this project," or "We must not reduce services during the conversion." Fritz concurs by stating that reaching an agreement on a project philosophy can be one of the most difficult parts of the project, but is one of the first tasks that must be completed. In conjunction with the project philosophy, goals must be set and key issues must be addressed. Only then, can planning and tasks identification begin (Fritz 1987).

Project Director and Key Staff

Within the article The Creation of a Coordinated Ambulatory Care System, Robert L. Slaton relates his project experiences and points out the immediate need for a project director. The individual who fills the project director position should have ultimate responsibility and authority for the development, implementation, and management of the project. There is also the need for an advisory committee which is charged with duties as determined by the project director. The committee should be comprised of about 15 members from all disciplines affected by the project (Slaton 1991).

In her article, Helen Abrams points out that the right mix of clinical and business people working together will create a balance of perspectives, values, concerns, and approaches to problem-solving and contribute to a successful implementation. Additionally, it is important to engage the clinicians as early as possible in the process (Abrams 1993).

Another alternative is the establishment of a Transition Coordinating Team consisting of key administrators. The team would be responsible for overall transition planning coordination, and execution of tasks (Handel 1983).

Implementation Tasks

After the management structure is established, an early activity is the identification of specific implementation tasks (Handel 1983). Using the brain-storming technique, small work groups can be used to identify specific tasks to be performed.

With this method, all tasks can be divided into three functional areas: facilities readiness, operations preparedness, and moving planning. Facility readiness tasks can be defined as those tasks required to ensure the facility is ready for occupancy.

Operations preparedness are those tasks that focus on review and update of policies, procedures, and methods to ensure appropriateness for the new operating environment. Moving planning encompasses those tasks necessary for the actual move (Handel 1983). In his experience, Handel found that for moving alone more than 900 tasks were identified. At first the tasks were tracked using computer software, but it was found early-on that this method was too time consuming and was stopped.

Personnel Considerations

Staffing requirements With any new project, changes in personnel are inevitable. A thorough analysis of staff requirements will identify new needs as well as obsolete positions (Munn 1992). Any additional new employees should be hired well in advance of opening. This is done to ensure proper orientation, training, evaluation, and ultimately a smooth operation from the first day of the project completion and opening (Jaeger 1988).

Staff Involvement Lloyd, an avid promoter of planning and commitment, recommends involving the staff early on. Interestingly, he says the primary reason that involvement works is because each person is just selfish enough to ensure his/her area of responsibility is well tended. Ultimately, the

overlapping effect of the selfish motive will work to assure the overall success of the project. Handel recommends keeping the staff informed, especially if there is a lengthy planning process. A monthly or weekly transition newsletter is one such way (Handel 1983). Additionally, everyone must understand their role in the project and know the project's ground rules. This may be accomplished by using departmental meetings (Womack 1992).

Education and Training Jean Dols strongly supports the need for project planning, especially in staff related issues such as education. She believes the staff considerations of an implementation plan are much less obvious and can be easily forgotten or overlooked. All plans should provide educational and informational programs to cover questions such as: where should the staff be on the actual day of the move, which telephone numbers will be kept and which ones will be changed.

Jaeger proposes the idea that training should begin months prior to opening. He feels that each department should devise a training program and that weekly training sessions are not too often.

Equipment Requirements

Because of long lead times, equipment needs should be identified early in the project life cycle. Equipment acquisition should begin no later than six to eight months prior to the earliest occupancy date. Often, state-of-the-art equipment requires greater lead times. Each department needs to conduct an equipment review. The review should include a current

inventory, total equipment needs, which existing equipment can fill those needs, new equipment requirements, and where each piece of equipment will be placed (Jaeger 1988).

It should be kept in mind that some equipment must be affixed to the facility structure and complicated technical equipment may have to be installed by the vendor (Jaeger 1988). Then all equipment must be thoroughly tested and problems fixed prior to occupancy. Additionally, backup systems must be included in the equipment planning. Finally, arrangements for transfer, storage, or disposal of equipment no longer needed must be planned (Womack 1992).

Facility Upgrade

Womack believes the literature is abundant with topics concerning facility master planning and the like, but fails to address the Executive Staff actions needed to bring a project to fruition. So he recommends an implementation system that performs a facility upgrade or remodeling using several linear steps to include:

Step one: Widely disseminate information concerning the project process. Communications are crucial to success.

Step two: Establish a project philosophy. This lodestar is used to guide the project from the project's very start.

Step three: Decide how you are going to operate during construction. Determine if you vacate or work around the upgrade.

Step four: Establish decision criteria to plan departmental

moves. Movement criteria statements usually include items such as: Patient care will continue, the impact on daily operations will be minimized, and the number of moves will be minimized.

Step five: Insist on staff involvement at every opportunity. Their acceptance, ownership, and input are essential.

Step six: Ensure that everyone understands their role in the project.

Step seven: Each department must plan its equipment and furniture needs well in advance.

Step eight: Minimize inconvenience every way possible, to both staff and patients.

Step nine: Develop good working relationships with key agencies, both internally and externally.

Step ten: Let your patients know what you are doing. When clinics and corridors are closed patients become easily confused. Help to alleviate this problem using news media, consumer meetings, and signs to direct traffic. It is important to be alert for those who require the personal touch.

In Paul Sommers article Managing Multispecialty Medical Services, he states space must be carefully considered. He believes patient accessibility and convenience to those services most often utilized should be kept in mind when programming office space. It is important for patients and families to be able to easily locate the service when they arrive for their first appointment (Sommers 1984).

Moving

According to Lockwood, the physical move is just one part of what needs to happen. He sees it a five-part process, encompassing building readiness, equipment readiness, operations start-up, communications and orientation, and (finally) the physical move itself. The planning should start early and a team should be organized along the lines of the five parts of moving (Lockwood 1992).

Handel agrees and carries it a step further by saying that relocating to a new facility is much more than moving staff and equipment. It not only is a new place for delivering care, but also represents a new way of providing care. It is a social phenomenon that can be either a positive or negative experience, but almost always generates some stress for both staff and patients (Handel 1983).

In order to simplify relocation of medical services, Ronan recommends the use of a facilities-coordination committee. The committee should be comprised of representatives from eight key areas: nursing, information management, departmental liaisons, administration, housekeeping, materials management, facilities engineering, and security. The committee should meet at least twice a month and discuss needs, activities, and tasks associated with the physical move (Ronan 1990).

Opening and Activation

In Jaeger's article concerning the planned opening and activation of facilities, he supports the need for opening and

activation activities and states they entail several major substeps. He provides five major substeps that must begin as construction nears completion. They include: 1) non-contract equipment installation; 2) orientation, training, and recruitment; 3) supplies and furnishings; 4) public relations programs and promotion; and 5) the actual move. In reality, I believe the steps may run concurrently and steps will impact on other steps. He also strongly supports the idea of a shake-down period prior to opening in order to test all equipment and systems.

Post-Opening

Perhaps the most overlooked part of any project is post-occupancy. It should involve evaluation, adjustment, and celebration. Questions should be asked such as: What is right or going well? What needs to be changed? What effect do the changes have on work flow and patient outcomes? What is the effect on staff behavior and satisfaction (Munn 1992)?

It is also important to celebrate the opening. It presents an excellent opportunity to acknowledge and thank the staff for their hard work, input, expertise, and patience (Munn 1992). Handel also recommends post-move activities to celebrate the transition and reinforce a sense of accomplishment.

In his article concerning moving, Lloyd says to anticipate initial unhappiness with the new environment, dissention, and even depression that occurs after the move is made and project implementation is complete.

Handel discusses the need for the continuation of project meetings for a number of weeks after implementation. Meetings should include key project personnel, administrators, department heads, and head nurses. The purpose of the meetings are to critique and focus on ongoing operational questions and issues. It is a good idea to continue the newsletter at least for one month after project completion. Finally, Lloyd raises the point that there has never been a project completed without some error. He says to recognize that no one is perfect and there will be mistakes, oversights, and errors made.

Propositions

There is no one best way to convert to PCCs because all facilities differ. But it is possible to analyze BACH's implementation process and experiences in order to determine common themes applicable to all MTFs desiring to make the change to PCCs.

Second, no matter how much planning is done on any project of considerable size, opportunities for improvement exist.

Purpose

This case study sought to analyze BACH's implementation of primary care clinics and develop a conceptual model for converting the traditional military single specialty outpatient clinics to multi-specialty primary care clinics by analyzing the unit of analysis and the crucial variables.

Unit of Analysis/Study Variables

In this study, the primary care clinics' implementation is

considered the unit of analysis. The implementation tasks, logistical and personnel requirements, and parties responsible for performing identified tasks are the crucial variables in question.

Objective

The primary objective is to develop a highly functional implementation blueprint by identifying tasks, requirements (logistical, personnel, etc.), and opportunities for improvement during BACH's PCCs implementation.

METHODS AND PROCEDURES

This Graduate Management Project (GMP) is a project where the management skills obtained during the didactic phase of the U.S Army-Baylor University in Healthcare Administration can be utilized. Those skills allow the author to assist the hospital staff in converting selected specialty outpatient clinics to three consolidated primary care clinics. In order to do this the author performed the following:

The author collected, reviewed, and analyzed all internal documentation concerning BACH's primary care clinics and their implementation. In addition, the author documented personal observations concerning the implementation of the PCCs.

The author attended command and departmental meetings concerning the PCCs and their implementation. Additionally, the author met with individuals on a one-on-one basis to discuss the project. In order to get a broad perspective, the author met

with project members throughout the chain of command, both military and civilian. Specific interviewees are stated in the Validity and Reliability section below.

The author continued to conduct literature searches using medical libraries such as BACH's and Vanderbilt's; and used the Fort Campbell and surrounding area collegial libraries. In addition, author included in the research efforts Department of Defense and Health Services Command literature and policies. Finally, the author utilized non-refereed literature, such as the Wall Street Journal, as an aid to keep abreast of the most current changes and issues concerning primary care clinics.

The study included data concerning: personnel requirements, logistical requirements, tasks requirements, coordination, problems encountered, and opportunities for improvement. Using the data, the author traced and analyzed all phases of BACH's PCCs' implementation and recommended improvements for similar projects.

It is important to note that the PCC project was initiated in November of 1992 and the author became involved shortly after his arrival at BACH in August of 1993, after the departures of some key project personnel. Therefore, the author does not claim any credit for the implementation of PCCs.

Study Design

This Graduate Management Project employs a descriptive case study method to analyze the implementation of BACH's primary care clinics. The author selected two primary references to assist in

my study project. They are: Robert K. Yin's book Case Study Research, Design and Methods and Catherine Marshall's Designing Qualitative Research.

Validity and Reliability

Validity

In his book, Robert K. Yin recommends the use of at least one of three techniques to enhance construct validity: multiple sources of evidence, chain of evidence, and case study review by key informants. In an effort to ensure construct validity, the study used two of these techniques. First, it used multiple sources of evidence by using data collected from project documentation, interviews, observation, and participant-observation. As a minimum, interviewees included the: Commander, Deputy Commander for Administration; Deputy Commander for Clinical Services; Chief, Department of Primary Care and Community Medicine; Chief, Clinical Support Division; Chief, Information Management Division; Chief, Coordinated Care Division; and Chief, Coordinated Care Section.

Second, the study employed another construct validity enhancing technique of having the case study reviewed by a key participant, the Deputy Commander for Administration. The objective here was to assure the reviewer agreed with case facts, but not necessarily with conclusions and interpretations.

It is generally agreed among researchers that proof of external validity has been a major problem to single case studies. This is mainly because quantitative research relies on

statistical generalizations while case studies rely on analytical generalizations. Because of these limitations, the applicability of generalization, or lack there of, are argued or established by providing richness of sources within the case study document.

Reliability

To assist in ensuring reproducibility of the case study results, a case study database (approximately 100 pages), as recommended by Yin, was established, maintained, and submitted with the case study. The database consists of two separate collections: (1) the data or evidentiary base and (2) the report. The data or evidentiary base consists of case study notes, case study documents, tabular materials, narratives, and all other forms of information generated concerning the initiation and implementation of the primary care clinics.

RESULTS

This study analyzed Blanchfield Army Community Hospital's Primary Care Clinics implementation process. For the most part, the analysis found BACH's PCCs implementation process to be sound. But, as explained in the analysis within the Discussion chapter, opportunities for improvement do exist.

Using information derived from the case study analysis, project documentation, and research efforts, an implementation blueprint for a multi-specialty primary care clinic was developed and is presented in Appendix A. Appendix A, a stand alone document, provides general project information, a directed

narrative, staffing levels by specialty, required equipment, an implementation schedule, and a post-opening evaluation plan.

The blueprint is predicated on a single clinic model designed to accommodate the primary care need of 13,500 up to 15,500 active duty dependents and/or retirees, non-acute patients, but is designed to be easily expandable. Those beneficiaries with medical problems beyond the scope of the primary care clinics, normally retirees, should be referred to internal medicine physicians or other specialists.

The discussion section provides an insightful and thought provoking analysis of BACH's management of the PCCs implementation. Appendix A in concert with the Discussion chapter provides a firm foundation for a facility considering the conversion to the multi-specialty primary care clinic(s).

DISCUSSION-ANALYSIS

This section provides an analysis and recapitulation of BACH's management of the PCC implementation process. The analysis parallels the topic headings found in the Literature Review section. Opportunities for improvements, where found, are included within the topic headings. Wherever appropriate and possible, extracts of project documents are placed in the text, as inserts. This is done to provide the reader with a fuller understanding of BACH's implementation, and to enhance the richness of the sources within the text.

On November 15, 1993 Blanchfield Army Community Hospital

began operating three hospital based multi-specialty primary care clinics. In final form, the three clinics are designed to have four family physicians, two pediatricians, a general medical officer, two physician assistants, two nurse practitioners, two telephone health care advice nurses (THCAN), and two decentralized appointment clerks. See Insert 3 on page 40.

The author contends that their opening was the culmination of a fairly successful eleven months implementation process, a process which remained on-time and within the estimated costs. Table 4 provides summaries of estimated implementation costs and actual incurred costs.

TABLE 4

SUMMARY OF COSTS		
	Estimated	Actual
Medical Equipment	\$218,065.00	\$82,100.00
Installation Property	46,526.00	46,526.00
Marketing	122,292.00	47,846.00
Facility Modifications	15,350.00	15,350.00
Communication Support	12,000.00	49,380.00
Automation Support	19,236.00	19,236.00
TOTAL	\$433,469.00	\$260,438.00

Implementation Recapitulation

The idea of BACH's primary care clinics was born in January of 1993 as a result of BACH's desire to establish a more accessible, more efficient, and more accountable primary care system. Previous efforts centered on establishing a Primary Care of the Uniformed Services (PRIMUS) clinic. After conducting an on-site analysis, Health Services Command denied funding for the PRIMUS clinic project. In the after-action report, dated 23 November 1992, HSC officials stated that there were sufficient staff to fully empanel the catchment area population with BACH providers (Appendix B, Exhibit A). They based the findings on a 40 mile catchment area beneficiary population of 74,095 at a physician to patient ratio of 1,750. In addition, the report recommended more effective management of primary care medical assets and the use of primary care provider panels.

Within 30 days of the report's issuance, BACH's Deputy Commander for Clinical Services (DCCS) issued a memorandum declaring that BACH would implement multi-disciplinary health care teams (Appendix B, Exhibit B). In this memorandum, dated 26 January 1993, he stated that the health care teams would consist of Family Practice physicians, physician's assistants, nurse practitioners, midwives, and the necessary ancillary support. Additionally, the DCCS commissioned a Process Action Team (PAT) to consider BACH's delivery of primary care. While the DCCS's rapid response to expeditiously solve the problem of primary care delivery is commendable, it brings certain aspects of the

project's marketing plan into question and provides initial opportunities for improvement.

Marketing

The management of the primary care clinics' marketing failed to receive an appropriate level of attention. When reviewing the PCCs marketing plan, the author found only a brief one page and general outline that only addressed promotional aspects. See Insert 1. From interviews with the Chief, Coordinated Care Branch and the DCCS, the author determined that a formal market analysis to define the target population, and their needs and wants was not conducted. Instead, catchment area beneficiaries statistics, provided by Health Services Command, was substituted (McCorkle 1994). This data was several years old and provided only the broadest view of the customer population. Additionally the HSC beneficiary figure was based on an arbitrary 40 mile radius. The resulting figures were inaccurate since there are a significant number of eligible beneficiaries, avid users, that reside in the Nashville area, outside the 40 mile radius. Additionally, the data failed to specify beneficiaries by categories such as needs, age, gender, and system user.

At least two opportunities for improvement exist in the marketing portion of BACH's primary care clinics implementation, the market analysis and the selection of the target market. Promotion, another portion of marketing, is discussed in the Opening and Activation section.

INSERT 1

Marketing and Staff Education

RESPONSIBILITY: DCCS/DPCCM/CCD/DON

Marketing

<u>REQUIREMENTS</u>	<u>CURRENTLY HAVE</u> <u>ON HAND</u>	<u>NEED/COST</u>	<u>DATE</u> <u>AVAILABLE</u>
<u>Personnel</u>			
1 GS-03 Temporary Intermittent On-Call Office Automation Clerks		\$ 17,875	FY94 Gateway to Care Primary Care Business Plan
<u>Educational</u> <u>Marketing</u>			
Healthwise		40,807	
Hope Health Newsletter		28,400	
Magnets		17,710	
Printing costs for Red-White Blue Primary Care Clinic Handbooks		3,200	
<u>Enrollment</u>			
PRC Cards		6,800	
Embossers 1@ \$7,500 ea		7,500	
TOTAL COST		\$122,292	

Marketing will involve providing education on preventive measures to increase beneficiary responsibility for self-care, and providing information about policy and program changes with regard to the Primary Care Clinics. The effort will target active duty soldiers and their family members, and retired service members and their family members.

Traditional channels of communication (newspaper, unit and neighborhood briefings, other special interest group gatherings) will be utilized.

INSERT 1 CONTINUEDStaff Education

The education effort will be aimed at the entire spectrum of BACH staff, not just those directly involved with the operation of the Primary Care Clinics. General audience information will be publicized through MEDDAC PULSE articles and briefings by members of the Primary Care Clinic Process Action Team.

Focused information will be presented periodically to departmental QA&I committees by the DCCS and CCD. Additionally, incoming physicians will receive training regarding the Primary Care Clinics concept during inprocessing.

More indepth training will be conducted for the Primary Clinics' staff members. Physicians will receive training from the clinic OICs, the DCCS, and the Chief, DPCCM. The nursing and ancillary staff will receive training from the Department of Nursing.

Opportunities For Improvement. A thorough marketing analysis should have been the first step when considering changes to BACH's delivery of primary care services. The author considers marketing not merely as the promotion of the clinics but includes defining the customer population and their needs. For any similar project, the author strongly recommends the use of an initial market assessment. It is imperative to clearly define the target population, scope of services to be provided (product), the optimum place to serve the customer, and the right mix of promotion.

The author believes Health Services Command was in error when concluding a 1,750 patients per 1 physician ratio is proper (Appendix B, Exhibit A). Nowhere in the memo is the ratio justified and it fails to address normal market analysis's points of patient mix and acuity mix. According to the DCCS, the ratio may be acceptable for civilian physicians, but it is too high for the military provider, due to the additional demands of military service. The BACH staff should have strongly refuted this ratio and justified a higher staffing level with the accompanying funds. From his practical experience, Blanchfield's Deputy Commander for Clinical Services recommends a ratio more on the order of 1100 or 1200 patients per physician (DCCS 1994).

Target Market Constrained by capitated budget, limited resources, and regulations, BACH is forced to make hard decisions concerning beneficiaries' care. One such decision was to place Medicare eligible beneficiaries' access to the primary care

clinics on a space available basis (Appendix B, Exhibits D and M). At first glance, it seems logical to place the Medicare eligible population in a "seen on a space available basis" category, since BACH is neither reimbursed for Medicare eligible retirees nor provided funds in the annual budget for these individuals.

Closer scrutiny reveals that such a policy is contrary to good managed care, as shown in the following paragraphs. As stated in project documentation, the system is to provide enhanced primary care access to active duty dependents, and CHAMPUS eligible retirees (Appendix B, Exhibit P). Medicare eligible retirees' access to primary care, for all intents and purposes, is severely restricted in this initiative. Insert 2 provides a breakout of the PCC's beneficiary population. It is obvious from Insert 2 that Medicare eligible retirees have significantly less access. As seen below, this policy has the distinct possibility of becoming penny wise and dollar foolish.

The Medicare eligible population's access problem is unique only to outpatient services. Since bed days and inpatient census have been declining over the past couple of years, admitting these Medicare eligible beneficiaries is done routinely. In essence, for these patients BACH is foregoing the less expensive primary care (preventive) and is opting to provide them more expensive inpatient curative care. This policy is contrary to tenants of managed care, which state: provide the appropriate level of high quality care at the lowest possible cost.

INSERT 2
Clinic Assignment Plan

RESPONSIBILITY: DPCCM

<u>RED CLINIC</u>		<u>WHITE CLINIC</u>		<u>BLUE CLINIC</u>	
(Fmr Peds Clinic)		(Fmr FP Clinic)		(Fmr OB Clinic)	
1st BDE	- 2817	3rd BDE	- 2715	2nd BDE	- 2806
160th SOAR	- 1667	AVN	- 4189	DISCOM	- 4323
101st SG(C)	- 3157	5th SFG	- 1761	DIVARTY	- 2148
326th Eng	- 860	LEC	- 589	2/44th ADA	- 664
501st Sig	- 776	MEDDAC/DENTAC	- 300	HHC Div	- 543
MEDDAC/DENTAC	- 300	CID	- 62	311th MI	- 554
USAICS	- 48	1/58th	- 147	MEDDAC/DENTAC	- 360
529th Eng	- 2	TDS	- 26	902nd MI	- 4
535th Eng	- 5				
	9617		9789		11402
Retiree FP	- 833	Retiree FP	- 833	Retiree FP	- 833
Retiree w/kids	- 1000	Retiree w/kids	- 1000	Retir w/kids	- 1000
					13235
				PLUS:	
				Spec Peds	- 1500
	11465		11622		14735
DIVIDED BY					
NUMBER OF					
PROVIDERS	10		10		13
AVE/PROVIDER	1145/Provider		1162/Provider		1133/Provider

Opportunity For Improvement. Provide Medicare eligible beneficiaries better access to primary care. It is generally accepted among managed care experts that by more closely managing primary care the more costly inpatient episodes will be reduced. Additionally, closely managing prescriptions, via primary care, should result in an overall reduction of pharmacy expenditure incurred from this population.

Any facility considering the use of a multi-specialty primary care clinic should closely scrutinize the Medicare eligible population's overall use of the facility. The author submits that the costs incurred by providing this population greater access to the less expensive primary care, is compensated for by a reduction in their inpatient costs. Since the Medicare population consumes a considerable portion of all DoD healthcare dollars, the author recommends all of their care be managed as if the medical facility were receiving Medicare reimbursement.

PROJECT PHILOSOPHY AND GOALS

Formal project philosophies and goals were not a part of the PCC implementation. When reviewing all available project documentation and conducting numerous interviews the author found no evidence of any formal project philosophies. On the other hand, several informal philosophies evolved throughout the life of the implementation.

During interviews, each interviewee received an explanation and example of project philosophy and was then asked three

questions pertaining to a PCC project philosophy.

1. Were you aware of a PCC project philosophy, formal or informal?
2. If so, what was it?
3. Was it widely disseminated?

Without exception, all interviewees were unaware of any formal project philosophy, but thought there were some informal philosophies. They were: "Minimize inconvenience for patients and staff"; "We will aim for a zero sum gain of personnel for this project," and "We must not reduce services during the conversion."

The author found much the same when looking at the projects goals. The same two methods, a review of all project documentation and interviews, were used to determine if formal or informal project goals existed. A review of project documentation found one document, a BACH news media release that very briefly mentioned the project goals. The document stated that delivering primary medical care more efficiently, and providing patients better access to this care are the goals behind the PCC project (Appendix B, Exhibit R).

During the interviews, each interviewee received an explanation and an example of project goals and was then asked three questions concerning a PCC goals.

1. Were you aware of a PCC project goals, formal or informal?
2. What were they?
3. Were they widely known?

Once again without exception, all interviewees were unaware of any formal goals, but were aware of informal goals. Interestingly, all recapitulated the goals stated in the news release, plus one other. It was, "Each clinic will assume total responsibility for all of its beneficiaries' care.

Opportunity For Improvement. During BACH's PCC implementation process, insufficient emphasis was placed on providing a formal project philosophy(s), formal goal setting, and dissemination of this information. It is of critical importance to a project's success that a project philosophy be established and goals set at the earliest possible date. The project philosophy acts as a decision making guide throughout the project. Goals provide a target at which to aim, and also provide one of the reference points used in measuring a project's success.

Project Director and Key Staff

Project Director. The author observed, that a formal and full-time project director was not appointed for the PCC implementation. Instead, the responsibilities of this position were informally divided between two physicians, the Deputy Commander for Clinical Services (DCCS) and the Chief, Department of Primary Care and Community Medicine (C,DPCCM). From observation, the author found that they worked together well and their management and leadership styles were complementary.

By virtue of his position, the DCCS assumed many of the director's responsibilities in addition to providing strong

leadership throughout the project's implementation. While this author viewed many of the DCCS's actions as one of an approving authority, his strong leadership abilities were critical to the projects's successful implementation. This point cannot be overstated.

Two events observed by the author vividly portray the DCCS's leadership ability. First, as a leader he was able to share and sell his vision of the PCCs almost unanimously among the non-physician staff, beneficiaries and other force commands at Fort Campbell. Second and more importantly, he was able to get the physicians to buy into the project. As seen in the next paragraph, this may have well been the most important factor of the project's successful implementation.

Fort Polk MEDDAC's recent failure in attempting to institute a similar primary care delivery system clearly illustrates the importance of physician leadership and the need for the physicians to buy into the vision. At the Army Seminar conducted during the 1994 American College of Health Care Executives Conference, Fort Polk MEDDAC's DCCS largely attributed their recent project's miserable failure to the physicians' resistance to the new primary care system. The author, as well as the DCCS, believe that the failure, may also be attributed to lack of leadership from the Fort Polk's DCCS and hospital commander.

Blanchfield's Chief, Department of Primary Care and Community Medicine (C,DPCCM) assumed more of the operational, day to day, responsibilities and details of project implementation.

The author found him to be an extremely skillful organizer, coordinator, and communicator.

Even though a formalized and full-time project director was not appointed, the symbiosis of these two physicians, their abilities, and their talents greatly attributed to the successful and on-time implementation of the PCCs. But this sort of arrangement does have significant drawbacks.

First, the unofficial co-directing of the project created considerable confusion among numerous staff members concerning who had what authority. This was mentioned in several of the author's interviews. Second in the author's mind, the likelihood of two such individuals being brought together and successfully co-directing another major project on a part-time basis is, at best, remote. Therefore, the author does not recommend this style of project management.

Opportunity For Improvement. The author recommends that future projects have a formal and full-time project director. The individual who fills the project director position should have ultimate responsibility and authority for the development, implementation, and management of the project. The project director should monitor, track, direct and maintain the project's progress. Also this person can help to alleviate or reduce duplication of effort by becoming the coordinating point for all actions. In the same vein, the position should be given the responsibility for the assignment and sequencing of all implementation tasks. Additionally, this position should be the

coordinating point for all project implementation decisions.

Key Staff. Blanchfield Army Community Hospital's use of an implementation planning staff, as the key staff, was a model of excellence and is the heart of the project's successful implementation. From the very start, numerous staff members, in the form of a process action, team were included and strongly involved.

In a memorandum from the DCCS, dated 26 January 1993, minimum process action team (PAT) membership was established (Appendix B, Exhibit B). The initial team members were selected on one of two of criteria. First, some were selected to represent those areas that would be affected by the reorganization. Others members were selected by virtue of their expertise in certain areas. Table 5 is taken from the 26 January 1993 memo and lists the initial PAT membership. As seen in Appendix B, Exhibit C the membership greatly expanded.

The team was given the charge of refining the PCC concept and planning the project's implementation. They met the second and fourth Friday of each month, with the first meeting on 12 February 1993. The author found that the team consistently met through the end of June 1993 (Appendix A, Exhibits D - K). According to the DCCS, after this time, meetings were deemed not to be required. Instead, PAT subcommittees established by each clinic met every Thursday until opening day (Hardy 1994).

TABLE 5PROCESS ACTION TEAM MEMBERSHIPPHYSICIANS

Chief, Department of Medicine

Chief, Family Practice

Chief, Pediatrics

Chief, Department of Primary Care and Community Medicine

NURSES

Chief, Department of Nursing

Head Nurse, Family Practice

Head Nurse, Pediatrics

Chief, Ambulatory Nursing

Chief, Nursing Midwives

ADMINISTRATIVE

Chief, Clinical Support Division

Chief, Coordinated Care Division

Chief, Information Management Division

Patient Appointment System Supervisor

Patient Administration Division

Public Affairs Officer

Implementation Tasks

The identification and execution of implementation tasks were well managed. The author observed that these functions were decentralized and segregated by organizational activity, such as the Logistics Division, Department of Nursing, and so forth. Early on, activities were given the responsibility of identifying major implementation tasks. The task lists varied in completeness and depth among the activities. The author attributes this to the differing approaches used to develop the lists (delegation, brainstorming, etc.), dedication to task list development, and lack of task list development guidance and standardization. The Chief, Information Management Division was charged with the responsibility of compiling the activities' task lists and inputting them into a software program designed to track projects and develop tasks sequencing (DCA 1993). After the initial compilation of tasks, activities were then instructed to develop all sub-tasks associated with the major tasks. At this point, many activities failed to comply with the sub-task request. From observation, the author attributed this behavior to the lists' administrative burden and the perception of small returns for effort spent. The computerized project tracking was so time consuming that it became a project within a project and was terminated about six months prior to project completion.

Personnel Considerations

During the February 26, 1993 meeting, the PAT directed that an analysis be performed to determine current staff assets, PCC

staffing requirements, and staffing shortfalls (Database). Inserts 3 through 5 present required personnel, on-hand personnel, and estimated costs of hiring unmet requirements. Due to budgetary constraints, the PAT recommended, whenever possible, shift staff around and not hire new staff (Appendix B, Exhibit E). As discussed in the next section, this philosophy led to an unanticipated problem and an opportunity for improvement.

Opportunity for Improvement. The PAT's decision to avoid hiring new staff and only using current assets to staff the PCCs, cost more than it saved in numerous ways. During the author's interview with the Deputy Commander for Clinical Services, he stated that, in retrospect, the project was undercapitalized. As a result, BACH was never able to meet the number of projected providers and other staff. Thus, the clinics opened understaffed, with each clinic short one telephone health care advice nurse and a physician.

According to the Deputy Commander for Clinical Services, the under-staffing problem was magnified for the first few weeks of the PCC's operations. Because of newness of the operations, the staff and clinics were not as efficient as desired and ultimately possible. As a result, many patients became disenchanted with the new system early on. Patient complaints soared and the PCCs image suffered considerably. As important, some of the staff became frustrated with the new system (Hardy 1994).

Over time operational problems were reduced, efficiencies increased, some image and trust regained, and frustration levels

minimized. For future projects, probable initial staff inefficiencies should be compensated for by temporary over-staffing (Hardy 1994).

INSERT 3
Health Care Providers

RESPONSIBILITY: DCCS/CSD	CURRENTLY HAVE		DATE
REQUIREMENTS	ON HAND	NEED/COST	AVAILABLE
FP Physicians 4ea clinic Total = 12	12	0	Now
PED Physicians 2 ea clinic* Total = 6	6	0	Now
*Special Ped & EFMP Phys in Blue Clinic Total = 2	2	0	Now
GMO Physicians 1 ea clinic Total = 3	3	0	Now
PAs 1 ea clinic **Total = 4	3	1 *\$45,460	FY94 Gateway to Care Primary Care Business Plan
Nurse Pract. 2 ea clinic Total = 6	5	1 *\$76,500	FY94 Gateway to Care Primary Care Business Plan

* These costs will be incurred and are cost-effective whether or not the Primary Care Initiative is implemented.

**The Blue Clinic will have two (2) PAs

INSERT 4

Administrative Support

RESPONSIBILITY: CSD/DON

<u>REQUIREMENTS</u>	<u>CURRENTLY HAVE ON HAND</u>	<u>NEED/COST</u>	<u>DATE AVAILABLE</u>
PAS Clerks 2 ea clinic Total = 6	6	0	Now
Clinic Receptionist 3 ea clinic Total = 9	9	0	Now
<u>ACSB</u>			
1-Chief	1	0	Now
2-NCOs	2	0	Now
1-Clerk	1	0	Now
<u>DPCCM Admin</u>			
Secretary	1	0	Now

INSERT 5

Ancillary and Nursing Support

RESPONSIBILITY: DON

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Head Nurse 1 ea clinic **Total = 3	3	0	Now
NCOIC 1 ea clinic Total = 3	3	0	Now
LPN 3 ea clinic Total = 9	9	0	Now
Nurse Asst. 7 ea clinic Total = 21	21	0	Now
Telephone Health Care Advice Nurse 2 ea clinic Total = 6	3	3 * \$120,000	3 Avail Now 3 Required. FY 94 Gateway to Care Primary Care Business Plan

* These costs will be incurred and are cost-effective whether or not the Primary Care Clinic Initiative is implemented.

** The Blue Clinic has a Head Nurse (RN) and another RN due to their Special Pediatrics and EFMP mission.

Equipment Requirements

Blanchfield's acquisition of clinic equipment was a true success story and should be emulated whenever possible. The Chief, Logistics Division was responsible for all equipment actions. According to the Chief, Logistics Division, each clinic was tasked to conduct an equipment review. The review included a current inventory, total equipment needs, which existing equipment could fill those needs, and new equipment requirements.

In a discussion with the Chief, Logistics Division, he related the following. Approximately 120 days prior to opening day, each clinic had developed an initial list of equipment needs. Shortly thereafter, the Logistical Branch compiled the clinics' list and estimated total equipment costs. Because BACH's budget could not totally accommodate the costs, another method of procurement was sought. The answer was found in the Chief, Clinical Support Division's proposal to procure equipment from a BRAC site, specifically Fort Ord.

The Chief, Logistical Branch coordinated with the closing facility, Silas B. Hayes Army Hospital (SBHAH), to send an equipment scouting party. The scouting party reviewed SBHAH property books and FAXed copies of pages back to BACH for further review. Once equipment was identified for transfer it was loaded on rental vans and driven back to BACH.

Since the equipment was a property book transfer, BACH incurred no costs and realized an equipment cost avoidance of about \$136,000. Additionally, the rental van costs were covered

by BRAC funds (Heidenheim 1994). INSERTs 6 and 7, are estimates of the total implementation equipment requirements, to implement the clinics. Estimated costs are also included but maintenance and training costs are not factored into these figures.

Prior to opening day, the staff tested all equipment and most problems fixed prior to opening. Additionally, some backup systems for critical equipment, included in the initial plan, were available on opening day (Hale 1994). Finally, arrangements for transfer, storage, and disposal of equipment no longer needed was well planned and executed.

INSERT 6

Medical Equipment

RESPONSIBILITY: LOG/DPCCM

REQUIREMENTS	CURRENTLY ON HAND *	NEED/COST TOT COST	DATE AVAILABLE
(3) Changing Tables	0	3 \$ 300 \$ 900	*
(50) Exam Tables	29	21 4800 100,800	
(69) Stools	27	42 65 2,730	
(10) Mayo Stands	2	8 148 1,184	
(42) Procedure Carts	21	21 450 9,450	
(22) Dopplers	13	9 800 7,200	
(20) Goose Neck Lamps	0	20 300 6,000	
(2) Vital Station Mons	0	2 2100 4,200	
(18) Two Panel Illumins	1	17 217 3,689	
(4) Infant Scales	0	4 3000 12,000	
(4) Adult Scales	0	4 500 2,000	
(2) Infusers	0	2 700 1,400	
(3) Hand-Held Opths	0	3 100 300	
(4) Portable Nebulizers	0	4 220 880	
(2) Adult Laryngoscopes	0	2 103 206	
(2) Pediatric L-scopes	0	2 103 206	
(1) Colposcopes	0	1 8000 8,000	
(3) Bovies	0	3 5200 15,600	
(1) Flex Sigmoidoscope	0	1 5000 5,000	
(1) Retropharyngoscopes	0	1 4500 4,500	
(2) Tympanometers	0	2 3198 6,396	
(5) Tympanic Therms	0	5 514 2,570	
(5) IVAC thermometers	4	1 288 288	
(2) Life Pak 8s	0	2 7500 15,000	
(34) Wall Mtd Otoscopes	21	13 582 7,566	
TOTAL		\$218,065	

* Date available determined by potentially different means for each piece of equipment. BRAC site equipment can be available almost immediately. Equipment costing less than \$1,000 is bought with OMA funds and can be on hand in 60-90 days. Equipment costing between \$1,000 and \$15,000 is purchased under the Capital Expense Equipment Program (CEEP) with OMA funds and can be on hand in 90-120 days, depending on the priority for purchasing the item as established by the local Program, Budget and Acquisition Committee (PBAC). Delivery times can be shortened somewhat if the requisition is labeled as "priority" and if the vendor has the item in stock at the time of the requisition.

INSERT 7

Installation (Station) Property

RESPONSIBILITY: LOG/DPCCM

REQUIREMENTS	CURRENTLY ON HAND *	NEED/COST TOT COST	DATE AVAILABLE
(2) Magazine Racks	0	2 \$ 250 \$ 500	See Previous Page
(55) Office Desks (L)	18	37 286 2,002	
(80) Chairs	40	40 85 3,400	
(43) 5-Drawer Cabinets	16	27 160 4,320	
(40) Trash Cans	16	24 65 1,560	
(15) Partitions	0	15 275 4,125	
(20) Literature Rack	0	20 25 500	
(16) 3-Shelf Bookcases	0	16 65 1,040	
(2) L Shaped Desk	0	2 200 400	
(16) Small Tables	0	16 175 8,000	
(2) Storage Cabinets	0	2 150 300	
(32) Clocks	0	32 15 480	
(2) Water Piks	0	2 200 400	
(2) Coat Racks	0	2 75 150	
(2) End Tables	0	2 100 200	
(10) Metal Cabinets	4	6 1200 7,200	
(25) Addressographs	11	14 400 5,600	
(3) Emergency Carts	0	3 783 2,349	
(1) Partition Set	0	1 4000 4,000	
TOTAL		\$46,526	

Facility Upgrade

For the purpose of this study, the facility upgrade is divided into four areas: structural upgrades, telephone system upgrades, automated call distribution system upgrade, and automation upgrades. The structural upgrades, telephone system upgrades, and the automation upgrades were well planned and executed. The same can not be said for the automated call distribution system upgrade.

Structural Upgrades. The Chief, Logistics Division was responsible for structural upgrades. Few facility upgrades were required for the primary clinics implementation, and all were conducted smoothly with little disruption of services or operations. Additionally, information concerning the project's upgrade progress was widely disseminated and often, upgrade recommendations were elicited from the staff. One such example was the staff's strong involvement in the placement of structurally mounted equipment in the clinics. The author observed that the Command well understood staff involvement, as well as, good communications, were crucial to the implementation's success.

Early in upgrade planning, the Command surmised there was no reason to vacate patient care areas and decided that patient care would not be diminished. This minimized the impact of upgrades on daily operations significantly.

The author observed that during the planning and execution of the facility upgrades two informal and unwritten project

philosophies evolved. First, was the policy and effort to minimize moves. According to the Nurse Methods Analyst, this philosophy had some influence on the space utilization. Closely related, was the second informal philosophy of minimizing inconvenience every way possible, to both staff and patients. This included efforts to keep the patients informed. BACH staff made a concerted efforts to seek out and assist patients who seemed to be misoriented or confused by the PCC changes. The author noted on several occasions members of the BACH staff using a personal touch with people walking the hospital's corridors. Any future projects should emulate the BACH's staff attitude and performance in this area. INSERT 8 contains BACH's PCC project facility upgrade requirements, costs and estimated time to completion.

INSERT 8

Facility Modifications

RESPONSIBILITY: LOG

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Install Locks; Ward 3AC	0	\$7,700	#GB00174-3J 70 Days
Install Lights Otosopes and CATV Outlet Remove TVs & Locks;Ward 3AC	0	5,400	#GB00177-3J 70 Days
Install Drapes and Track; Install Otoscope Brackets; Old OB Clinic	0	750	#GB00183-3J 70 Days
Install Drapes and Track in Old Peds Clinic	0	500	#GB00182-3J 70 Days
Fabricate & Install New Signage	0	1,000	
Total	0	15,350	

Telephone System Upgrades. The Acting Chief, Information Division (C,IMD) was responsible for telephone systems upgrades. The author found the upgrades of the telephone system were well planned, well executed, and costs were well controlled. Since the telephone system is a significant factor of access, it was imperative that BACH scrutinize the telephone system capabilities and affect on the PCCs.

During the February 26, 1993 PAT meeting, concerns were voiced about patient complaints and surveys that had repeatedly identified patients' inability to get through to an appointment clerk on the telephone as a significant problem at BACH. The PAT identified the problem as post wide. At that time, Fort Campbell had only 105 incoming and 54 outgoing telephone lines (Appendix B Exhibit O). The PAT determined that those were an insufficient number of lines needed to support the PCC goal of increased access, and would hinder the PCC's success. In March of 1993, the PAT recommended and the Command decided that BACH must take measures to improve the telephone access in order to successfully implement the primary care clinics.

According to the Acting Chief, Information Management Division, the team decided to bypass the Fort Campbell switch by obtaining 30 trunk lines connected directly to the BACH telephone system. As explained in the Automated Call Distribution Upgrade section, these lines are dedicated to the primary care clinics' via the automated call distribution system.

After reviewing several requisition and funding options, the

Command decided that BACH would initially lease the lines and submit an unfinanced requirement to Health Services Command to install the additional trunk capability. Costs for the telephone line upgrade included a flat installation fee of \$2,320, and a monthly charge of \$1,849 for service.

According to the C,IMD, along with the increase in trunk lines, numerous telephone lines had to be moved internally, and there was a need to increase the numbers of telephone lines and instruments in each clinic. While the act of physically moving or installing the new telephone requirements was fairly easy, the associated administrative requirements was burdensome and time consuming (Davis 1994). For each telephone line moved within the facility, a DA3938 had to be submitted up the chain of command to Signal Command. The clinics averaged about 32 telephone devices and 36 telephone lines each (Davis 1994). Inserts 9, 10, and 11 are compilations (by clinics) of these changes as determined by the IMD.

INSERT 9

Communication Support -- Red Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Move 5 Telephone Numbers		5	Within 48 Hrs
Install 2 New Telephone Numbers		2	Within 48 Hrs
Move 7 Telephone Instruments		7	Within 24 Hrs
Install 2 New Telephone Instruments		2	Within 24 Hrs
Install 2 New Cables		2	60 Days

INSERT 10

Communication Support -- White Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Move 1 Telephone Numbers	2	1	Within 24 Hrs
Install 5 New Telephone Numbers	33	5	Within 48 Hrs
Move 1 Telephone Instruments	32	1	Within 24 Hrs
Install 3 New Telephone Instruments	32	3	Within 48 Hrs
Install 1 New Cables	33	1	60 Days

Remarks: Work order for conduit and receptacles must be submitted through Pat Hancock.

INSERT 11

Communication Support -- Blue Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Move 2 Telephone Numbers		2	Within 24 Hrs
Install 8 New Telephone Numbers		8	Within 48 Hrs
Move 0 Telephone Instruments		0	
Install 5 New Telephone Instruments		5	Within 24 Hrs
Install 0 New Cables		0	

Remarks: 2CU04 - 2 new numbers, 1 new instrument
 2CU01 - 1 new number
 2CU03 - 2 new numbers, 1 new instrument
 2CU06 - 1 new instrument
 2CT48 - 1 new number, 1 new instrument
 2CT20 - 1 new instrument
 2CT14 - 1 new number, 1 new instrument
 2CT09 - 1 new number

Automated Call Distribution System Upgrade Author's Note:

Unless otherwise noted, most of the narrative concerning the ACD Upgrade is derived from the author's observations and participation in numerous ACD meetings.

The upgrade of the automated call distribution system, known as the ACD, was problematic, remains troublesome, and provides ample opportunities for improvement. The upgrade began two years prior to PCC concept development, with the ACD (Meridian 1 by Northern Telecom) module already scheduled to be added to the existing system. Thus, not all ACD costs can be attributed to the PCCs. The PCCs' portion of the costs totalled \$45,211. The costs were as follows: \$36,766 for 8 voice mail ports; \$7,000 for 30 ACD ground start cards; \$925 for a digital announcer; and \$520 for 6 ACD compatible head sets.

A grasp of the ACD's operation is helpful prior to discussing the upgrade's opportunities for improvement. According to the Chief, Communication Center, there are 30 lines dedicated to the PCCs that feed into the ACD. The ACD and clinics, can only be accessed by dialing one of two numbers, 798-HOSP (4677) on-post, and 431-HOSP off-post. Calls that come into the system on incoming trunks are first answered by the ACD. Once the call is answered by the ACD, the caller, using a touchtone phone, can work through the five levels of menus until reaching the desired clinic. At this point the caller may access one of two clinic appointment clerks, one of two telephone health advice nurses, leave a non-urgent message for a provider, or

coordinate a prescription refill. If all clinic lines are busy the caller is placed in a queue and the calls are answered in the order they are received (Boyd 1994).

Opportunities For Improvement Management of the PCC portion of the ACD upgrade leaves numerous opportunities for improvement. From the first hour of its use, the ACD generated large numbers of complaints. It is still a significant source of aggravation to beneficiaries and promoter of ill will. Prior to the ACD activation, the average monthly total of telephone systems complaints was 2 with 21 additional requests for assistance. In the first month of ACD operation, there were 110 ACD complaints and 40 other requests for assistance (Bleyle 1994). Currently, the ACD complaints are averaging 65 per month (Appendix A, Exhibit S).

While the concept of marrying the ACD with the primary care clinics 30 trunk lines was good, it was the "how" that caused severe problems. An example of one such "how" was the failure to test the system prior to the PCC's opening morning. November 15, 1993, 07:30 (opening day) was the first time the very complicated system was turned on, tested, and the first time staff had a chance to train with the system.

Actually, errors in the ACD implementation began early on. At the outset, the PAT decided to use BACH's Information Management Division staff, not a consultant to manage the PCC's communication implementation. The author submits this was an error. While the IMD staff was familiar with the system's

operation, they were not aware of the need for, and the intricacies of decision making tools such as queuing models. Thus, decision making tools were never used to assist in the designing of menus and menu levels, or determining the number of phone ports and queue sizing. Instead, these items were designed and determined by well meaning, dedicated, and hard working BACH staff; but not experts. As mentioned previously, results have been unfavorable.

To compound the problem, accurate beneficiary data was not obtained during the marketing stage, so any ACD decisions were made with dated and, very likely, inaccurate data.

Initially, there were five levels of lengthy and tedious menus. They were time consuming, somewhat confusing, and irritating. Once a person reached a clinic's queue, it could be hours before a human voice was heard. This resulted from limits not being placed on the size of each clinics' queue. According to the Chief, Communications Center, on one occasion there were more than a thousand people stacked in one of the PCC's queue. Shortly after this phenomenon was discovered, the clinic's queue size was reduced to five. This was a "seat of the pants" reactive decision made with little or no prior analysis. The change only worsened an already bad situation. With the queue full at five callers, everyone else was told, by the ACD voice, that all lines were busy and to call later. Then the ACD quickly disconnected the caller. This infuriated many callers.

In an effort to solve the problem, BACH finally hired a communications consultant to come in for a day, review the situation and make recommendations to alleviate the ACD problem. The consultant stated optimum system efficiency would be obtained only if the appointment system was centralized. Her recommendation was never instituted, and the system has yet to be improved. The ACD queues are still set at five and BACH still has no idea of the demand placed on the system or how to correct the problem.

For any facility planning to institute the PCC concept, the author has several communication recommendations. First spend the money to hire a communications consultant early on. This will be money well spent. You would not ask a communications expert to write medical protocols. Why ask a medically trained person to develop ACD protocols? Next, during the marketing phase do your homework, identify the target market and their needs/wants. Doing this will help predict the demand that will be placed on the telephone system, and may identify new system requirements. The old cliché of trash in, trash out holds true for systems design. Also, test the communication system and train your staff at least two weeks prior to opening. Finally, keep in mind there is no quality without access!

Automation Upgrades. The Acting Chief, Information Management Division was responsible for PCC automation upgrades. Analysis of documentation and observations leads the author to believe this portion of the project was well managed and timely

in nature, which was quite a feat. As explained in this section, the author strongly recommends getting IMD involved in the upgrade planning as soon as space issues are settled.

Early on, automated equipment requirements and tasks were identified and execution time lines developed. Initially, to the author, it did not appear that the automation portion would be difficult or extremely time consuming. In fact, it was very complicated and numerous hours were consumed on the upgrades for the PCC implementation, in addition to the IMD's other daily duties.

The author observed that the equipment installation and structural upgrade was the easiest portion of their tasks. It was the administrative requirements that complicated and burdened the upgrade.

According to the Acting Chief, Information Management Division, each telephone line moved within the facility, required a DA3938 be submitted up the chain of command to Signal Command. In order to get the upgrade cable pulled, IMD had to submit conduit work orders to BACH's Logistics Division. In turn, the Logistics Division submitted the work orders to Fort Campbell's Contracting Branch for competitive bid. Once the contract was awarded, the paperwork was routed back through the chain and the contractor was contacted to perform the work. Also work orders (with room maps) had to be submitted to Services Branch for all LAN and AQCESS drops. Turn around time for work orders and requests took approximately 90 to 120 days.

orders and requests took approximately 90 to 120 days.

Automation requirements, equipment needs, and response times are listed in Inserts 12 through 16.

One other IMD management success is worth noting: their approach to equipment placement sites. IMD asked the clinics' staffs to select placement of the automation equipment. More accurately, they gave them that responsibility. IMD ensured site selections were finalized well in advance of the first work order of DA form being typed, thus, reducing duplication of work, reducing installation costs, and reducing staffs' dissatisfaction.

INSERT 12

Automation Support -- Move Ward 3AC to 4AA

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Conduit	Not installed	\$275 flat fee 850' @ \$1.10 per ft / \$1000	60 Days
0 AQCESS Terminals	0	0	
0 AQCESS Printers	0	0	
0 AQCESS Drops	0	0	
1 LAN Drop	1	0	
1 MEPRS Drop	0	1 line \$150	60 Days
2 LAB Printer Drops	0	2 lines \$250	60 Days
1 PC	1	0	
Total		\$1,675	

INSERT 13
Automation Support -- Move Ob/Gyn Clinic to 3AC

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Conduit		\$275 fee 2800' (\$1.10 per foot/ \$3100)	60 Days
6 AQCESS Terminals	6	0	Now
2 AQCESS Printers	2	0	Now
8 AQCESS Drops	0	8 / \$1100 (600' each)	60 Days
3 LAN Drops	1	2 / \$50 (220' each)	60 Days
0 MEPRS Drops	1	0	N/A
1 LAB Printer Drop	0	1/\$110 (460')	60 Days
1 PC	1	0	Now
TOTAL		\$4,635	

INSERT 14

Automation Support -- Red Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Conduit		\$184 flat fee \$2730 new conduit	60 Days
5 AQCESS Terminals	5	0	Now
2 AQCESS Printers	2	0	Now
7 AQCESS Drops	2	5 / \$660 (600' each)	60 Days
3 LAN Drops	1	2 / \$300 (650' each)	60 Days
0 MEPRS Drops	0	0	N/A
1 LAB Printer Drop	0	1 / \$50 (100')	60 Days
1 PCs	0	1 / \$2000	60 Days
Total		\$5,924	

INSERT 15

Automation Support -- White Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Conduit		\$184 flat fee \$834	60 Days
4 AQCESS Terminals	4	0	Now
1 AQCESS Printer	1	0	Now
5 AQCESS Drops	3	2 / \$500 (1000' each)	60 Days
5 LAN Drops	1	4 / \$250 (650')	60 Days
0 MEPRS Drops	0	0	N/A
1 LAB Printer Drop	1	0	Now
0 PCs	0	0	N/A
Total		\$1,768	

Remarks: 2 LAN drops are for Patient Rep
 1 LAN drop is for Admin Resident

INSERT 16

Automation Support -- Blue Clinic

Responsibility: Information Management Division

REQUIREMENTS	CURRENTLY HAVE ON HAND	NEED/COST	DATE AVAILABLE
Conduit		\$184 \$2,000	60 Days
5 AQCESS Terminals	5	0	Now
1 AQCESS Printer	1	0	Now
6 AQCESS Drops	2	4 / \$800 (800' each)	60 Days
4 LAN Drops	1	3 / \$250	60 Days
0 MEPRS Drops	0	0	N/A
1 LAB Printer Drop	1	0	Now
1 PC	0	1 / \$2000	60 Days

Total

\$5,234

Space Utilization

Space utilization and requirements identification, though complicated issues, were managed admirably. According to the Nurse Methods Analyst (NMA), several factors complicated the placement of the clinics. The clinical space at BACH is a scarce resource. Each of the PCCs required large areas with significant numbers of exam rooms. To further confound the problem, the clinics needed to be thoughtfully placed so as to afford patients easy access. Additionally, she stated that an informal project philosophy of minimizing moves and operational disruptions had to be considered. The NMA was given the task of analyzing current hospital space utilization and making recommendations on where and how to accommodate the PCCs (Appendix B, Exhibit N).

The space analysis resulted in a plan providing excellent access for two of the clinics (Red and Blue), while providing less than optimal access for the third (White). The Red and Blue clinics were placed a short distance from the outpatient clinics main entrance, on the second floor. The White Clinic was placed on the third floor and is a little more obscure. The author does not believe that the White Clinic's placement will adversely affect the overall success of the PCCs. but it is a detractor.

A series of sequenced moves were required to accommodate the clinics. The following is a recapitulation of those moves as stated by the NMA. The surgical ward was moved from 3AC (a third floor ward) to 4AA (an empty fourth floor ward) about six months prior to the PCCs opening. The move consolidated all surgical

inpatients to the same floor. About two weeks prior to the PCCs' opening, the first floor OB/GYN clinic moved to 3AC, leaving their vacated area for the Blue Clinic. Red Clinic inherited the Pediatric Clinic (first floor) once the Pediatric staff was dispersed to the PCCs. Finally, the Family Practice Clinic area became White Clinic (third floor).

Movement

Movement planning began early on, with the organization of decentralized clinic moving teams and informal planning groups (Simpson 1994). Also during this period, one of the project's informal philosophies evolved, minimize equipment movement. Instead of each clinic taking its equipment in the move, it was decided that equipment would be left in place and hand receipts adjusted (Simpson 1994). This policy was a true work and time saver.

The physical movement was well managed by the BACH staff. Movement planning called for the physical move to be performed during a Fort Campbell four day weekend, 11 November through 14 November 1993. In actuality, the staff began the moving process on the afternoon of Nov. 10th, but took off Nov. 11th, a federal holiday. Even though Nov. 12th was a holiday for the 101st Division, it was a moving day for the clinics. Equipment movement proceeded ahead of schedule, and by the end of the day it was complete. Contrary to original planning, the weekend was not required for moving.

The author found that scheduling the move on an extended weekend was an astute move with several advantages. First, it allowed maximum amount of moving time with no disruption of patient services, since the hospital outpatient clinics would be closed. Second, the closing of the clinics, freed the clinics' staff to participate in the move. Finally, the normally high volume of patients in hallways was significantly less. Thus, allowing greater ease of equipment movement. The author strongly recommends scheduling such moves on a three or four day weekend, and compensate the clinics' staff for the missed time off at a later date.

Opening and Activation

Overall, the opening and activation were well managed. These tasks encompassed the clinics' pre-opening promotions, equipment testing, and last minute preparations.

The promotion of the primary care clinics was multifaceted, and began about eight weeks prior to opening day. Initial efforts began with unit briefings. The DCCS, the C, DPCCM, and staff from the Coordinated Care Division briefed military units, inprocessing service members, dependent groups, staff, and any other units requesting a PCC briefing. On average, the BACH staff performed seventy briefings per month.

The local media was another avenue used to disseminate information to the public and promote the PCCs. Articles written by the BACH staff, including this author, were printed in every local newspaper (Appendix B, Exhibit R). Weekly, The Fort

Campbell Courier, ran articles describing the PCCs and detailing clinic assignment for dependents and retirees.

Promotional expenses totalled \$47,846. These were incurred as follows: Healthwise Handbooks - \$40,000; Embossing cards - \$5,406 and; refrigerator magnets - \$2,440 (McCorkle 1994).

Another of the opening and activation tasks, the operational shakedown and testing of equipment, was performed concurrently with the moving and installation of the equipment, with one major exception, upgrading the telephone system. Because the new telephone system was not activated until opening day the appointment clerks and telephone health care advice nurses did not have a chance to perform any hands on training (Hale 1994).

During opening and activation, the author observed several management points worth noting and emulating. First, on the final moving afternoon each clinic had a potluck luncheon for clinic staff, as well as, any other hospital employees who desired to attend. The event served two purposes, it provided closure to the implementation and it was a good team builder. The luncheons were well attended and upbeat in nature.

Prior to opening, there was considerable concern that patients would have a difficult time finding the clinics, even though the clinics were centrally located, and signage was ample. In an effort to thwart such a problem, one of the clinics' staff members proposed that all three of the clinics be decorated with extremely large ribbons in the color of the clinic. This brilliant idea was adopted and was very successful.

Also notable was the Red Clinic's staff efforts towards team building during the opening. Red Clinic staff members privately purchased red T-shirts with a Red Clinic logo and wore them on opening day. This immensely enhanced the staff's morale and displayed their pride and enthusiasm (Hale 1994). The author recommends the facility encourage such displays and provide the funds when possible.

According to the Head Nurse of the Red Clinic, on the first day of operation, the PCCs were open only for the first half of the day. The second half of the day was used for individual clinic after action meetings and operation adjustments (Hale 1994). Additionally, representatives from all clinics and the command staff met to identify and correct common or severe problems. These were excellent management moves. The clinics opened for full day operations on Tuesday, 16 November 1993.

Post-Opening

The post-opening portion of implementation was managed fairly well, with two exceptions. For the first four days of the PCCs' operation, evening meetings were held to evaluate, adjust, and congratulate. These meetings were normally attended by the Command, PCCs' representatives, Department of Nursing, IMD, Quality Management, health care administrators, and the administrative resident. Each meeting was a critical review of the day's operations. Questions were asked such as: What is right or going well? What needs to be changed? What effect do the changes have on work flow and patient outcomes? What is the

effect on staff behavior and satisfaction? While scheduled working group meetings were discontinued after this period, ad hoc groups met as needed to address issues and solve problems. The author sides with Handel, believing the working groups should have continued for a number of weeks after implementation.

Opportunities For Improvement. It has been five months since opening of the clinics and, BACH has yet to scientifically evaluate the results of the changes made in the delivery of primary care. In the early stages of implementation, two evaluation plans were developed. The plan presented in Insert 17 was to evaluate the success of change. As shown, it covers numerous aspects and has multiple measures for the project's success. The author believes the plan has merit and should be performed. The plan is incorporated in Appendix A.

There was one other evaluation plan developed as a personal research project (Appendix B, Exhibit P). The Chief of Family Practice developed five PCC satisfaction surveys. The five differing questionnaires were to be administered to providers, active duty dependents, active duty soldiers, force commanders, and retirees. The bipolar survey was designed to be administered twice, before the treatment and three months after the treatment. To the author, it appears that considerable work went into developing the surveys. But according to the Chief of Family Practice, he never administered any of the surveys. He states that he could not find the time to do so because of his medical duties. The author finds this to be both a wasted opportunity

and wasted opportunity costs. Now, it is practically impossible to measure the PPCs effect on attitudes and preceptions, since the pre-survey was never administered.

INSERT 17

Evaluation Plan

RESPONSIBILITY: CCD/DPCCM

1. Objective: To develop and implement monitoring processes that identify and trend over, under or appropriate resource utilization by the three primary care clinics. In order to predict and measure the "success" of the change, a systematic review of "what is" is imperative for comparison. Are the right people doing the right things at the right time in the right place to the right people? UM monitoring provides data that identifies opportunities to improve utilization patterns and minimize waste.
2. Method: The following outline of indicator topics are suggested as a beginning evaluation and largely incorporate existing data sources. The following list expands on, and is conceptually based on "Measurement of Access to Care" required by HSC (Memo of 11 December 1992):
 - a. Customer Acceptability of the Primary Care Clinics
 - (1) # enrolled/total # possible
 - (2) # complaints by type/enrollees (QM)
 - (3) Trended data from patient satisfaction surveys (ie. C, FPC's survey)
 - b. Accessibility to Health Care

- (1) # enrolled using the EC and evening clinics
- (2) # on waiting or backlog lists/appointment type
- (3) # visits/type/enrollee

c. Availability/Accountability (Measures of workload, productivity and appropriateness of appointment scheduling and patient education efforts)

(1) Patients: Effectiveness of educating patients on their responsibilities for their own wellness and appropriate use of their primary care clinic and other BACH clinics.

(2) Provider compliance with appointment protocols and templates

- a. # of appointments available/type/provider
- b. # of appointments filled with "walk-ins"
- c. # of admission and re-admissions
- d. # of No Shows and Cancellations

(3) Continuity of Care measures: Develop consensual provider criteria to analyze hours of operation and the impact of provider call scheduling on continuity and availability (ie. following patients admitted, OB workload and delivery workload).

d. Cost Containment

(1) Cost per clinic visit using MEPRS Cost by Medical Specialty and Coordinated Care Partnership Report

- (2) Analysis of workload distribution by provider type
- (3) Comparative analysis of clinic and provider profiling (ie. workload, ordering practices, NAS's, disengagements, use of consults)

e. Impact of change

- (1) Changes in other clinic workloads (ie. Outpatient Clinic, Emergency Center)
- (2) Changes in use of ancillary support services
- (3) Patient satisfaction
- (4) User pattern changes
- (5) Provider satisfaction surveys
- (6) QM could quantify how quality is maintained while containing costs and improving access.
- (7) Outcome studies based on pattern analysis

3. In summary, the primary care clinics UM program will coordinate reporting and analysis of multiple data sources which demonstrate clinic and provider patterns of resource use. The goal is to identify and promote change in practice patterns. Focused studies from identified trends would help clarify areas of over utilization. Studies must be nonpunative, timely, effectively communicated in provider terms and be aimed at identification of underlying reasons for variances in resource use (Proposal 1993).

Opportunities For Improvement. One meaningful portion of BACH's PCCs implementation was omitted, the post-opening staff celebration. No such activities occurred. It was important to celebrate the opening of the PCCs. Such an occasion would have presented an excellent opportunity to acknowledge and thank the staff for their hard work, input, expertise, and patience. It would have also given closure to the implementation process.

CONCLUSIONS AND RECOMMENDATIONS

From the data derived in the course of this study it is evident that BACH's PCC implementation process was sound. It is also evident that opportunities for improvement exist. Based on the information developed in the course of this study, the following recommendations for improvement are offered.

1. Perform a thorough marketing analysis as the first step of the PCC implementation process. Clearly identify and quantify the customer population and their needs. Then, determine the scope of services to be offered, the place in which to offer these services, and develop a proper promotional mix.

2. Include the Medicare eligible population in the primary care equation. When considering this group it is, "pay me now or pay me later."

3. Early on, appoint a formal and full time project director.

4. As soon as possible, establish project philosophies and set project goals. These are vital to the project's acceptance and success.

5. Initially, over-staff the clinics to compensate for early inefficiencies. It will be hard to change your customers' first impression of the clinics.

6. Hire consultants if you are planning to upgrade high technology items such as telephone systems or the automated call distribution system. Use the right person for the job.

7. Formally evaluate the effect of the changes made in the delivery of primary care. Close the cybernetic loop, measure the success and modify as necessary.

Implication for Military Medicine

This study may have broad implications for the future of military medicine. Increasingly, emphasis is being placed on primary care as a means to enhance access, reduce costs, and maintain quality care. It is very much in the spectrum of possibility that many military clinics similar to the PCCs will be established in the near future. Additionally, the PCC is a novel and significant change in the way military primary care is delivered and there is little historical data concerning the implementation of similar military clinics. Thus, it is my belief that this study will have much utility in the future of military medicine. So, this study was completed with the idea in mind of providing insightful literature to other military medical facilities who may decide to take this course of action. In

fact, the author has been contacted by staff from two other MTFs requesting information on the PCC implementation process.

Recommendations for Further Research

The author believes good management dictates at least two areas in need of complementary research. First, research is sorely need to remedy the problems noted with BACH's automated call distribution system. This is of the highest order. Until this issue is resolved the customers' preception of the PCC clinics will be negatively skewed. Second, there is a strong need to measure the effects of the change in the way primary care is delivered. Without this research, it is impossible to definitively say what effects the change has made and any further adjustments would be a tantamount to a shot in the dark.

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APPENDIX A

MULTI-SPECIALTY

PRIMARY CARE CLINIC

IMPLEMENTATION BLUEPRINT

APPENDIX A
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PRIMARY CARE CLINIC BLUEPRINT

Overview

This appendix presents an implementation blueprint of multi-specialty primary care clinics that was derived from research efforts, the case study analysis, and project documentation. It is predicated on a single clinic model designed to accommodate primary care for 13,500 up to 15,500 active duty dependents and/or retirees, non-acute patients. Those beneficiaries with medical problems beyond the scope of the primary care clinics, normally retirees, should be referred to internal medicine physicians or other specialist. If needed, it is designed to be easily expandable or implemented in multiples.

The appendix is a three tier structure having a general narrative, a directed narrative, and tables/inserts. The general narrative, a distillation of the author's research and case study efforts, provides general (but important) information about the implementation process. Often, it refers the reader to tables/inserts to clearly relay the information of the primary care clinics. The author strongly recommends reading this section prior to venturing into the rest of the appendix.

The specific narrative synoptically addresses PCC specific points that are more conducive to description than charting. Much of this information was derived directly from BACH's project documentation.

The final portion, tables and inserts, provides PCC staffing levels by specialty, equipment requirements and costs, implementation schedule, and an evaluation plan. The information presented is predicated on conclusions derived during the BACH's PCC implementation, and interviews of BACH's staff. Differing facilities may find differing requirements.

General

Marketing

A thorough marketing analysis should be the first step when considering changes to the delivery of primary care services. Ensure the customer population and their needs are well defined. Use an initial market assessment to ensure there is a clear vision of the target population, scope of services to be provided (product), the optimum place to serve the customer, and the right mix of promotion. Possibly, hire an actuarial firm to define the population and design a computer-based model to assist in the marketing process. Once the target population is identified, use focus groups to gather data to more closely define the scope of services. After determining the scope of services, a targeted promotional campaign, and an evaluation using tools such as a consumer survey need to be conducted.

Project Philosophy and Goals

Establish primary care clinic project philosophies and goals. It is of major importance to the success and acceptance of the project that project philosophies are established at the earliest possible date. The project philosophy acts as a decision making guide throughout the project (Womack 1992). Reaching an agreement on a project philosophy can be one of the most difficult parts of the project, but is one of the first tasks that must be completed (Fritz 1987).

Examples of project philosophies that may be worth considering include: "We will minimize moves and operational disruptions;" "We must minimize inconvenience every way possible, to both staff and patients;" "We will maintain a zero sum gain of personnel for this project;" or "We must not reduce services during the conversion."

In conjunction with the project philosophy, goals must be set and key issues must be addressed. Goals provide a target at which to aim, and also provide one of the points of reference used in measuring a project's success. Only then, can planning and tasks identification begin (Fritz 1987).

Project Director and Key Staff

At the earliest possible date, appoint a formal project director, with this job being the individual's primary duty until project completion. The project director position should have ultimate responsibility and authority for the development, implementation, and management of the project.

There is also the need for a Project Key Staff. The staff is charged with duties as determined by the project director. The staff can take many forms, but it should be comprised of members from all disciplines and representatives of departments affected by the project. Table 1 is a recommended minimum PCC implementation staff membership.

Implementation Tasks

After the management structure is established, an early activity is the identification of specific implementation tasks (Handel 1983).

Table 8 contains lists of tasks and associated execution dates. The tasks are segregated along organizational activity lines.

Personnel Considerations

Staffing requirements Perform a thorough analysis of staff requirements to identify new needs as well as obsolete positions (Munn 1992). Any additional new employees should be hired well in advance of opening. This is done to ensure proper orientation, training, evaluation, and ultimately a smooth operation from the first day of the project completion and opening (Jaeger 1988).

Table 2 provides general PCC staffing guidelines.

Staff Involvement Keep the staff informed and involve them in the process early on. Use departmental meetings to ensure everyone understands their role in the project. Additionally, staff training should begin well in advance of opening.

Equipment Requirements

Because of long lead times, equipment needs should be identified early in the project life cycle. Equipment acquisition should begin no later than at least 180 days prior to the earliest occupancy date. Often, state-of-the-art equipment requires greater lead times. Each department needs to conduct an equipment review. The review should include a current inventory, total equipment needs, which existing equipment can fill those needs, new equipment requirements, and where each piece of equipment will be placed (Jaeger 1988).

It should be kept in mind that some equipment must be affixed to the facility structure and complicated technical equipment may have to be installed by the vendor (Jaeger 1988). Then all equipment must be thoroughly tested and problems fixed prior to occupancy. Additionally, backup systems must be included in the equipment planning. Finally, arrangements for transfer, storage, or disposal of equipment no longer needed must be planned (Womack 1992).

Military treatment facilities (MTF) should pursue procuring needed equipment from a BRAC site. Since the equipment is a property book transfer, no costs are incurred and equipment cost avoidance may be significant. Coordinate with the closing facility, to send an equipment scouting party. The scouting party can review MTF property books. Once equipment is identified for transfer, use a rental van(s) to transport the equipment back. The rental van costs may be covered by BRAC funds.

Prior to opening day, thoroughly test the equipment and correct problems. Additionally, arrange for backup systems for critical equipment. Tables 4 and 5 provide a general guide of medical equipment and installation property, and their 1994 costs.

Facility Upgrade

The facility upgrade may be divided into three areas: structural upgrades, communications system upgrades, and automation upgrades.

In military facilities, usually the equipment installation and structural upgrade are the easiest of the upgrade tasks. It is the administrative requirements that complicated and burdened the upgrade.

Each telephone line moved within the facility, requires a DA3938 be submitted up the chain of command to Signal Command. In order to get the upgrade cable pulled, conduit work orders must be sent to the Post Contracting Branch for competitive bid. Also work orders (with room maps) must be submitted for all LAN

and AQCESS drops. Turn around time for work orders and request takes approximately 90 to 120 days.

Communication and automation requirements, equipment needs, and response times are listed in Table 6.

When it comes time to determine equipment placement sites, have the clinics' staff select placement of the automation equipment. Finalize the site selections well in advance of the first work order of DA form being typed, thus reducing duplication of work, reducing installation costs, and reducing staffs' dissatisfaction.

A facility upgrade or remodeling can be seen as several linear steps to include:

Step one: Widely disseminate information concerning the project process. Communications are crucial to success.

Step two: Establish a project philosophy. This lodestar is used to guide the project from the project's very start.

Step three: Decide how you are going to operate during construction. Determine if you vacate or work around the upgrade.

Step four: Establish decision criteria to plan departmental moves. Movement criteria statements usually include items such as: Patient care will continue. The impact on daily operations will be minimized. The number of moves will be minimized.

Step five: Insist on staff involvement at every opportunity. Their acceptance, ownership, and input are essential.

Step six: Ensure that everyone understands their role in the project.

Step seven: Each department must plan its equipment and furniture needs well in advance.

Step eight: Minimize inconvenience every way possible, to both staff and patients.

Step nine: Develop good working relationships with key agencies, both internally and externally.

Step ten: Let your patients know what you are doing. When clinics and corridors are closed, patients become easily confused. Help to alleviate this problem using news media, consumer meetings, and signs to direct traffic. It is important to be alert for those who require the personal touch (Womack)

Moving.

The physical move is just one part of what needs to happen. It is a five-part process, encompassing building readiness, equipment readiness, operations start-up, communications and orientation, and (finally) the physical move itself. The planning should start early and a team should be organized along the lines of the five parts of moving (Lockwood 1992). For some facilities the use of a facilities-coordination committee may be appropriate. The committee should be comprised of representatives from eight key areas: nursing, information management, departmental liaisons, administration, housekeeping, materials management, facilities engineering, and security. The

activities, and tasks associated with the physical move (Ronan 1990).

Scheduling the move on an extended weekend is an astute move with several advantages. First, it allows for maximum amount of moving time with no disruption of patient services, since most hospital outpatient clinics are usually closed. Second, the closing of the clinics, will free the clinics' staff to participate in the move. Finally, the normally high volume of patients in hallways is significantly reduced. Thus, allowing greater ease of equipment movement. The author strongly recommends scheduling such moves on a three or four day weekend, and compensate the clinics' staff for the missed time off at a later date.

Opening and Activation

There is a need for opening and activation activities. These activities normally entail several major substeps: 1) non-contract equipment installation; 2) a shake-down period 3) orientation, training, and recruitment; 4) supplies and furnishings; and 5) public relations programs and promotion. In reality, these steps may run concurrently and steps will impact on other steps.

Use the local media as another avenue to disseminate information to the public and promote the PCCs. Have articles printed in every local newspaper, on a frequent basis. Start a series of articles that begins with general information and progressively becomes more detailed.

Prior to opening, use potluck luncheons for clinic staff, as well as, any other hospital employees to build the team, and a forum to share information. Also, use promotional items during the opening. Provide the clinics' staff with T-shirts, hats or similar items. These items enhance the staff's morale, as well as, display pride and enthusiasm.

Decorate the clinics for celebration and easy identification, even if the clinics are centrally located, and signage is ample.

On the first day of operation, open only for the first half of the day. The second half of the day can be used for a clinic after action meetings and operational adjustments.

Post-Opening

Conduct post-opening activities. They should involve evaluation, adjustment, and celebration. During the evaluation, questions should be asked such as: What is right or going well? What needs to be changed? What effect do the changes have on work flow and patient outcomes? What is the effect on staff behavior and satisfaction (Munn 1992)?

It is also important to celebrate the opening. It presents an excellent opportunity to acknowledge and thank the staff for their hard work, input, expertise, and patience (Munn 1992). Celebrate the transition and reinforce a sense of accomplishment.

Continue project meetings for a number of weeks after

Continue project meetings for a number of weeks after implementation. Meetings should include key project personnel, the command, administrators, department heads, and head nurses. The purpose of the meetings are to critique and focus on ongoing operational questions and issues. Remember that there has never been a project completed without some error. Recognize that no one is perfect and there will be mistakes, oversights, and errors made.

Finally, once the clinics are up and running smoothly, a scientific evaluation is needed to measure the resultant change and its direction. The most desirable method would incorporate the use of statistical pre and post implementation surveys or other sampling tools. Insert 1 provides one such plan evaluation plan.

Directed

Project Flow. The PCC implementation is a series of steps or issues . The space utilization and requirements issue must be resolved early in the PCC implementation, prior to many others being addressed. Table 3 addresses PCC space requirements.

The implementation schedule (Table 8) is dependent upon facility modifications, the acquisition of medical equipment (Table 4), installation property (Table 5), and communications/automation support (Table 6).

Administrative Relationships. The Primary Care Clinics are functionally integrated through an administrative network centered in the Department of Primary Care and Community Medicine (Figure 1). The Administrative Support Branch coordinates all clinic schedules, leaves, passes, TDY's, and other activities within the clinics. It prepares call schedules for the Family Physicians and Pediatricians assigned to the clinics and provides all other administrative support. An outline of the administrative support is contained in Table 2.

Nursing and ancillary support will be coordinated through the Chief, Ambulatory Nursing, who is co-located with the Chief, Primary Care and Community Medicine. An outline of the nursing and ancillary support is contained in Table 2.

TABLE 1**PHYSICIANS**

Chief, Department of Medicine
 Chief, Family Practice
 Chief, Pediatrics
 Chief, Department of Primary Care and Community Medicine

NURSES

Chief, Department of Nursing
 Head Nurse, Family Practice
 Head Nurse, Pediatrics
 Chief, Ambulatory Nursing
 Chief, Nursing Midwives

ADMINISTRATIVE

Chief, Clinical Support Division
 Chief, Coordinated Care Division
 Chief, Logistical Branch
 Chief, Information Management Division
 Patient Appointment System Supervisor
 Patient Administration Division
 Public Affairs Officer

TABLE 2

<u>Health Care Providers</u>	<u>Ancillary and Nursing</u>	<u>Administrative</u>
RESPONSIBILITY: DCCS/CSD	RESPONSIBILITY: DON	RESPONSIBILITY: CSD/DON
FP Physicians 4 ea clinic	Head Nurse 1 ea clinic	Pas Clerks 2 ea clinic
PED Physicians 2 ea clinic	NCOIC 1 ea clinic	Receptionist 3 ea clinic
Special Ped & EFMP Phys in	LPN 3 ea clinic	ACSB* 1-Chief 1-NCOs 1-Clerk
GMO Physicians 1 ea clinic	Nurse Asst. 7 ea clinic	
PAs 2 ea clinic	Telephone Health Care Advice Nurse 2 ea clinic	DPCCM Admin 1-Secretary
Nurse Pract. 2 ea clinic	*ACSB is Ambulatory Care Support Branch	

TABLE 3**Space Requirements**

RESPONSIBILITY: Nurse Methods Analyst

1. Requirements:

- a. Office space for providers
- b. Administrative office space
- c. Office for Phone nurses/appt. clerks
- d. Waiting and Reception area
- e. Treatment areas (NST, Lab)
- f. Storage and soiled utility rooms
- g. Toilets

2. Assumptions:

a. The standard of two exam rooms plus an office for each provider, often is not available. Accordingly each provider be allotted an office/exam room plus an exam room.

b. Staffing patterns (i.e. when 12 providers are assigned to an area on any given day, only 11 providers will be in the clinic) are generally accurate 90% of the time. During the remaining time 9-12 providers will be present. Therefore, eleven exam rooms will be sufficient for 12 providers 90% of the time.

3. Proposal:

(1) Twelve providers work out of each clinic. The requirements for each clinic are below:

- 12 Office/Exam rooms** (Office of the Chief will not include exam area)
- 11 Exam rooms**
 - 1 Office Phone Nurse
 - 1 Office appt. clerk
- 3 Treatment rooms*
 - 1 Soiled Utility
 - 1 Reception area
 - 1 Waiting area
 - 1 Triage area
 - 1 Lounge

* One room should be dedicated as an isolation room.

** All exam rooms should have hand washing sinks

TABLE 4
Medical Equipment

RESPONSIBILITY: LOG/DPCCM

REQUIREMENTS	COST*	TOTAL
(1) Changing Tables	300	300
(17) Exam Tables	4,800	81,600
(33) Stools	65	2,145
(4) Mayo Stands	148	592
(14) Procedure Carts	450	6,300
(7) Dopplers	800	5,600
(7) Goose Neck Lamps	300	2,100
(1) Vital Station Mons	2100	2,100
(6) Two Panel Illumins	217	1,302
(1) Infant Scales	3000	3,000
(2) Adult Scales	500	1,000
(2) Infusers	700	1,400
(2) Hand-Held Opths	100	200
(2) Portable Nebulizers	220	440
(2) Adult Laryngoscopes	103	206
(2) Pediatric L-scopes	103	206
(1) Colposcopes	8000	8,000
(1) Bovies	5200	5,200
(1) Flex Sigmoidoscope	5000	5,000
(1) Retropharyngoscopes	4500	4,500
(1) Tympanometers	3198	3,198
(2) Tympanic Therms	514	514
(2) IVAC thermometers	288	288
(1) Life Pak 8s	7500	7,500
(34) Wall Mtd Otoscopes	582	<u>19,788</u>

TOTAL \$142,691

* Prices current as of January 1994.

- 1) Recommend using as much on-hand equipment as possible or obtaining as much of the equipment as possible from BRAC sites to reduce costs.
- 2) Equipment costing less than \$1,000 is bought with OMA funds and can be on hand in 60-90 days.
- 3) Equipment costing between \$1,000 and \$15,000 is purchased under the Capital Expense Equipment Program (CEEP) with OMA funds and can be on hand in 90-120 days, depending on the priority for purchasing the item as established by the local Program, Budget and Acquisition Committee (PBAC).
- 4) Delivery times can be shortened somewhat if the requisition is labeled as "priority" and if the vendor has the item in stock at the time of the requisition.

TABLE 5**Installation (Station) Property**

RESPONSIBILITY: LOG/DPCCM

REQUIREMENTS	COST*	TOTAL
(1) Magazine Racks	\$250	250
(20) Office Desks (L)	286	5,720
(30) Chairs	85	2,550
(15) 5-Drawer Cabinets	160	2,440
(14) Trash Cans	65	910
(5) Partitions	275	1,375
(7) Literature Rack	25	175
(5) 3-Shelf Bookcases	65	325
(1) L Shaped Desk	200	200
(5) Small Tables	175	875
(1) Storage Cabinets	150	150
(13) Clocks	15	195
(1) Water Piks	200	200
(1) Coat Racks	75	75
(1) End Tables	100	100
(3) Metal Cabinets	1200	3,600
(8) Addressographs	400	3,200
(1) Emergency Carts	783	783
(1) Partition Set	4000	<u>4,000</u>
TOTAL		\$27,123

* Prices current as of January 1994.

TABLE 6**Automation/Communication Support**

Responsibility:
Information Management Division

Automation Requirements:

AQCESS Terminals
5 per clinic

AQCESS Printers
2 per clinic

AQCESS Drops
5 per clinic

LAN Drops
6 per clinic

MEPRS Drops
1 per clinic

LAB Printer Drop
1 per clinic

Personal Computer
1 per clinic

Conduit
As needed

Communication Requirements:

Telephone Lines/Numbers
38 per clinic

Telephone Devices
33 per clinic

Telephone Drops/Cable
33 per clinic

Automatic Call
Distribution (ACD) System

TABLE 7**Implementation Schedule**

RESPONSIBILITY: DCCS

The schedule for implementing the Primary Care Clinic proposal is demarcated in four sections by time-phasing. D-Day refers to the day the clinics will open.

D-200 Days

ACTIVITY	RESPONSIBLE AGENCY
Perform marketing analysis	CMD
Appoint Project Director(PD)	CMD
Appoint Key Staff	CMD/PD
Establish philosophies	CMD
Set project goals	CMD
Perform space utilization study	NMA
Perform staffing analysis	RMD

D-120 Days

ACTIVITY	RESPONSIBLE AGENCY
Procure Medical Equipment and Installation Property	LOG
Procure new signage	LOG
Begin Facility Modifications	LOG
Develop Nursing Staff Plan	DON
Take Action to Hire/Identify (3) THCANs for PCCs	DON/DPCCM /CCD
Assign staff to clinics	DCCS/DON /CSD
Distribute and assign telephone line/numbers	IMD
Submit changes in telephone numbers for new directory	IMD
Begin work to lease additional telephone lines	IMD
Submit unfinanced requirement for new trunk lines	IMD
Begin work to purchase additional voice ports	IMD
Install computer conduit	IMD
Install MEPRS drops	IMD
Install LAB printer drops	IMD
Install computer conduit	IMD
Install AQCESS drops	IMD
Install LAN drops	IMD
Purchase PCs	IMD
Complete first draft of PCC handbook	CCD/DPCCM
Conduct unit briefings	CCD
Develop or procure enrollment form	CCD
Order promotional materials	CCD
Begin PCC promotions	CCD
Send letters to Bde for unit briefing OK	CCD
Develop training plan for PCC staff	DCCS/CCD/ /DPCCM/DON
Gain consensus on UM monitoring criteria & definitions	DCCS/DPCCM /CCD
Conduct individual clinic IPRs	DCCS/DON

D-90 Days

ACTIVITY	RESPONSIBLE AGENCY
Procure medical equipment and installation property	LOG
Prepare QAI Plan for Primary Care Clinics	DPCCM/DON
Develop/Update SOPs, policies, procedures	DPCCM/DON
Develop THCAN protocols	DPCCM/DON
Prepare appointing SOPs for Primary Care Clinics	CSD
Conduct safety (personal protection) classes	Safety Off
Complete final draft of PCC handbook	CCD/DPCCM
Conduct unit briefings	CCD
Publish training materials for PCC staff	DCCS/DPCCM /CCD/DON
Coordinate with CPO for personnel job revisions in PCC	DON
Finalize UM monitoring procedures	DCCS/DPCCM /CCD
Conduct individual clinic IPRs	DCCS/DON

D-60 Days

ACTIVITY	RESPONSIBLE AGENCY
Procure Medical Equipment and Installation Property	LOG
Train Primary Care Clinic Staff on new policies	DON/DPCCM /CSD
Develop ACD voice menus	IMD/DPCCM
Install new cables	IMD
Install computer conduit in PCCs	IMD
Conduct safety (personal protection) classes	Safety Off
Beta test enpanelment	CCD
Conduct unit briefings	CCD
Publish articles in MEDDAC local news media regarding reasons for new PCCs	CCD
Send letters to retirees	CCD
Order promotional items	CCD
Send PCC handbook to reproduction	CCD/DPCCM
Conduct training for PCC staff	DPCCM/DCCS CCD/DON
Pilot UM monitoring procedures in FPC	DPCCM/DCCS CCD
Conduct individual clinic IPRs	DCCS/DON

D-30 Days

ACTIVITY	RESPONSIBLE AGENCY
Procure Medical Equipment and Installation Property	LOG
Identify equipment backorders	LOG
Install, test, and adjust new equipment	LOG
Turn in obsolete equipment	LOG
Train on new equipment	DPCCM/DON
Insure new leased telephone lines are working	IMD
Insure new voice processing ports are working	IMD
Conduct safety (personal protection) classes	Safety Off
Conduct unit briefings	CCD
Publish detailed articles in local news media regarding new locations and telephone numbers	CCD
Distribute PCC handbook	CCD/DPCCM
Conduct training and evaluate staff	DCCS/DPCCM / CCD/DON

D-10 Days

ACTIVITY	RESPONSIBLE AGENCY
Adjust property books and hand receipts	LOG
Install signage for new primary care clinics	LOG
Prepare MDS carts	LOG/MDS
Send new telephone numbers for PCCs to Install. Op.	IMD
Publish notice in installation bulletin regarding opening of PCCs	CCD
Reprogram ACD for new clinics	IMD
Test and adjust ACD	IMD

TABLE 13
D-3 Days

ACTIVITY	RESPONSIBLE AGENCY
Activate new telephone numbers and ACD	IMD
Move portable equipment and furniture to new PCCs	LOG
Test and train on clinic equipment	DON/DPCCM
Decorate for Opening	DON/DPCCM
Give staff Promotion items	DCCS

D-Day thru D+14

ACTIVITY	RESPONSIBLE AGENCY
Open clinics	Clinics
Perform daily after-action critiques	CMD/Clinics
Post-opening celebrations	All
Begin research planning	CCD/DPCCM /UM
Begin data collection	CCD/DPCCM /UM

Evaluation Plan

RESPONSIBILITY: CCD/DPCCM

1. Objective: To develop and implement monitoring processes that identify and trend over, under or appropriate resource utilization by the three primary care clinics. In order to predict and measure the "success" of the change, a systematic review of "what is" is imperative for comparison. Are the right people doing the right things at the right time in the right place to the right people? UM monitoring provides data that identifies opportunities to improve utilization patterns and minimize waste.

2. Method: The following outline of indicator topics are suggested as a beginning evaluation and largely incorporate existing data sources. The following list expands on, and is conceptually based on "Measurement of Access to Care" required by HSC (Memo of 11 December 1992):

- a. Customer Acceptability of the Primary Care Clinics
 - (1) # enrolled/total # possible
 - (2) # complaints by type/enrollees (QM)
 - (3) Trended data from patient satisfaction surveys (ie. C, FPC's survey)
- b. Accessibility to Health Care
 - (1) # enrolled using the EC and evening clinics
 - (2) # on waiting or backlog lists/appointment type
 - (3) # visits/type/enrollee
- c. Availability/Accountability (Measures of workload, productivity and appropriateness of appointment scheduling and patient education efforts)
 - (1) Patients: Effectiveness of educating patients on their responsibilities for their own wellness and appropriate use of their primary care clinic and other BACH clinics.
 - (2) Provider compliance with appointment protocols and templates
 - a. # of appointments available/type/provider
 - b. # of appointments filled with "walk-ins"
 - c. # of admission and re-admissions
 - d. # of No Shows and Cancellations
 - (3) Continuity of Care measures: Develop consensual provider criteria to analyze hours of operation and the impact of provider call scheduling on continuity and availability (ie. following patients admitted, OB workload and delivery workload).

d. Cost Containment

- (1) Cost per clinic visit using MEPRS Cost by Medical Specialty and Coordinated Care Partnership Report
- (2) Analysis of workload distribution by provider type
- (3) Comparative analysis of clinic and provider profiling (ie. workload, ordering practices, NAS's, disengagements, use of consults)

e. Impact of change

- (1) Changes in other clinic workloads (ie. Outpatient Clinic, Emergency Center)
- (2) Changes in use of ancillary support services
- (3) Patient satisfaction
- (4) User pattern changes
- (5) Provider satisfaction surveys
- (6) QM could quantify how quality is maintained while containing costs and improving access.
- (7) Outcome studies based on pattern analysis

3. In summary, the primary care clinics UM program will coordinate reporting and analysis of multiple data sources which demonstrate clinic and provider patterns of resource use. The goal is to identify and promote change in practice patterns. Focused studies from identified trends would help clarify areas of over utilization. Studies must be nonpunative, timely, effectively communicated in provider terms and be aimed at identification of underlying reasons for variances in resource use (Proposal 1993).

APPENDIX B

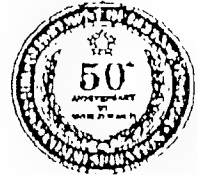
CASE STUDY DATABASE

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DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234-6000



REPLY TO
ATTENTION OF

HSC-LM (40)

23 November 1992

MEMORANDUM THRU Deputy Chief of Staff for ~~Clinical Services~~
FOR Chief of Staff

SUBJECT: Trip Report for Fort Campbell, KY, 18-20 November 1992

1. ADMINISTRATIVE DATA.

ACTIVITY VISITED: Fort Campbell, KY, and Blanchfield Army Community Hospital (BACH).

DATES: 18-20 November 1992.

PERSONNEL CONTACTED: Enclosure 1.

VISITORS: Enclosure 1.

TDY COST: \$4,950 @ \$550/person.

2. PURPOSE. To evaluate the capability of the U.S. Army Medical Department Activity (MEDDAC), Fort Campbell, KY, to provide enrolled primary care for the current and projected population. The Commander of the MEDDAC and the Chief of Staff, Headquarters, U.S. Army Health Services Command (HSC), requested this visit.

3. EXECUTIVE SUMMARY.

a. At 1300 on 14 October 1992, COL Xenakis, Commander, MEDDAC, Fort Campbell, KY, briefed the HSC Chief of Staff and other staff members, on a plan to provide primary care using a Primary Care of the Uniformed Services (PRIMUS) clinic. The HSC staff rejected this proposal as not being cost effective and COL Xenakis was advised to submit another proposal. At the same meeting, a HSC staff assistance visit was recommended to develop alternatives to the PRIMUS proposal. On 30 October 1992, COL Xenakis signed a memorandum, direct to the Office of the Surgeon General (OTSG), requesting an exception to the moratorium on PRIMUS clinics and that funding be provided to Fort Campbell for construction (Enclosure 2).

HSC-LM

SUBJECT: Trip Report for Fort Campbell, KY, 18-20 November 1992

On 9 November 1992, COL Xenakis signed the memorandum for the MC Distribution Conference which articulated the need for family practice physicians but did not place them as priority for fill or replacement (Enclosure 3).

b. The MEDDAC conducted an in-briefing which highlighted the need for additional primary care capability. Base line data (Enclosure 4) does not substantially differ from HSC data. At present, the MEDDAC has enrolled 3 brigades from the 101st Infantry Division (Air Assault) in family practice using 9 family practice physicians with approximately 1,750 patients per provider. The MEDDAC has also employed additional support personnel for this clinic to include a Health Care Advisor (HCA). This arrangement has provided empaneled care for approximately 30% of the active duty (AD) dependents and 13% of the retired population (Table 1). This divided enrollment has created a situation where there is a distinct "have and have not" mentality on the post. Those not enrolled in family practice believe they are getting poor quality care and do not have access to the system the rest of the post population enjoys. Meetings with the post command group and selected battalion/brigade commanders, retirees, and some family members, confirmed this impression. COL Xenakis has promoted this impression through his assertion that "mixed provider panels are not equal to the family practice design and (his) experiences at other locations have convinced him they will not work." The post community leadership strongly supports this assertion. They demand equity in health care defined as having everyone enrolled in a family practice panel with a FAMILY PRACTICE physician. They (the leadership) have been convinced that anything else is a "shell game" or "Army of Excellence (AOE)" revisited.

c. Detailed discussions with the MEDDAC staff and close analysis of the data show that the rest of the population is being treated by the current MEDDAC staff. The MEDDAC staff agrees but state this is not effective management and that this staff could not be devoted to develop a primary care panel for the remaining population. COL Xenakis is not willing to reallocate committed resources or programs to this effort and insists there is a requirement for additional investment. After intense negotiation, the proposal outlined on Table 1 was presented by the HSC team. This calls for the contracting of five family practice physicians and to the commitment of the rest of primary care staff from the MEDDAC. Based on this proposal, HSC recommended to COL Xenakis he withdraw the PRIMUS proposal and submit a primary care plan based on this concept.

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4. STAFF OVERSIGHT FINDINGS.

a. DCSRM.

(1) The MEDDAC's Fiscal Year (FY) 1992 Business Plan was successfully executed, and \$6.3M of Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) funds were authorized to be expended on four projects (Psychiatry, Surgery, Obstetrics, and Coordinated Care—a grouping of GATEWAY TO CARE start-up costs). Year-end budget figures reflect the MEDDAC reduced CHAMPUS claims approximately \$7.6M to net a \$1.3M CHAMPUS savings, clearly a success story. However, team review of the MEDDAC's primary care provider assets contradicts Fort Campbell's FY 93 argument that it is short providers and funding resources. The MEDDAC enjoys an average \$1,100 cost per beneficiary, the mean for all MEDDACs in the Command. The MEDDAC's FY 93 plan, if amended as described by MAJ Kocisak, will request about \$3M additional dollars, above the \$6.3M FY 92 amount, to expand inhouse services. An amount of \$1.3M would be shifted CHAMPUS to cover expansion in Psychiatry, Surgery, and Obstetrics. These costs initially appear recoverable. The remaining dollars were to fund a PRIMUS clinic, but this will be withdrawn and replaced by a \$2M request for primary care providers. This "to be developed" primary care cost is not supportable as an increase to programmed funds and questionable if covered as a CHAMPUS recapture initiative. If the MEDDAC truly believes there are CHAMPUS cost savings to cover this expense, so be it, but this kind of outpatient expense without true enrollment is a very risky recapture effort.

(2) The problem with the MEDDAC commander's rationale to price this \$2M dollar proposal is that he:

(a) Discounted the number of beneficiaries each assigned non-family practitioner (FP) could empanel (half the 1,750 figure now seen by his FPs).

(b) When he came up with two full-time employees (FTEs) short of current strength he said five were "really" needed.

(c) He took the collective cost of five FP FTEs at \$1M and said that was not enough, it should be \$2M. We can not afford his rationale.

(3) Bottom Line: Our team did not see a requirement to buy additional primary care providers outside of the resources now available to this MEDDAC. If Fort Campbell wants to risk recapturing additional CHAMPUS dollars to buy more

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primary care assets, they should present such a proposal. They can perform the mission with modifications presented by our team, but should they choose to expand primary care services they must do so within existing resources.

b. HCMEA. The staffing assessment model was presented to Judy Beard and with Mary McCorkle to demonstrate how it can be used to estimate manpower requirements in a managed care environment. Ms. Beard indicated she had minimal involvement in the business plan process and wasn't sure if the model was being used to formulate staffing needs. A copy of the model was given to Ms. McCorkle to explore options other than a PRIMUS clinic.

c. DCSIM.

(1) Telecommunications.

(a) Mr. Mazac evaluated the ongoing hospital switch upgrade which provides Automatic Call Distribution (ACD) capabilities to the coordinated care and patient appointing staff at BACH. Total upgrade cost is approximately \$150K. The 11-year-old Northern Telecom Incorporated (NTI) SL-1 is out-of-date and out-of-step with the brand of telephone equipment used on Fort Campbell. The upgrade will provide BACH the latest ACD features and posture the hospital for future telephone expansion through NTT's modular design. However, the upgrade will not bring BACH into conformance with the brand of telephone equipment used by the rest of Fort Campbell. This poses some problems, the main one being maintenance of the BACH switch. Because the Director of Information Management (DOIM) received severe cutbacks in telephone maintenance personnel, he only has one technician qualified to maintain the hospital switch. LTC Jones, DOIM, and CPT Ellerbe, Information Management Officer (IMO), have discussed the possibility of the hospital funding its own telephone technician(s). Because of the DOIM's 1,500 work order backlog, and an insufficient number of telephone technicians (6) for Fort Campbell, this traditional BASOPS responsibility may transfer to the hospital in order to satisfy BACH telecommunications' requirements.

(b) A second issue that surfaced during the visit was initialization and support for voice menus and mailboxes. When a switch is upgraded to perform ACD only the capability to do voice menus, voice mailboxes, information directories, etc., is provided. The setup and maintenance of these capabilities become a hospital IMO responsibility. While CPT Ellerbe and his staff are very capable and received training on how to setup these functions, the task is complex and labor intensive. Recommend future hospital

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ACD switch upgrades consider adding this task as part of the contractor's responsibility.

(2) Automation Support.

(a) The BACH received the Catchment Area Management (CAM) module of AQCESS in June 1992 to allow for local enrollment of their beneficiary population. LTC Potter, Chief, Coordinated Care, and CPT Ellerbe, Chief, Information Management, informed Ms. Leaders they are not using this capability. They gave no reason. Ms. Leaders suggested use of this module of AQCESS would lend management additional information on patient referral practices within the facility. Another function of the module allows for Other Health Insurance collection data. The Automation Management Officer at BACH developed a program for outpatient billing. Use of the CAM module would interface with this program without the necessity of dual entry.

(b) Ms. Leaders advised CPT Ellerbe and LTC Potter to begin using the capability they have to make their Coordinated Care Program function more efficiently in the automation area.

d. DCSCS (Ambulatory Care comments).

(1) COL Parry spent the day with MAJ Silkowski, Chief, Department of Primary Care and Community Medicine; LTC Maureen Potter, Chief, Coordinated Care Division; and COL Roy, Assistant Chief Nurse. Activities included a tour of the several Troop Medical Clinics (TMCs), the hospital outpatient, ambulatory surgery, labor and delivery areas, as well as, discussions of workload, staffing, and space allocation.

(2) The HSC workload, beneficiary population figures, and staffing statistics did not differ significantly from those of BACH. The major difference was in the number of retirees and their dependents in the catchment area. We agreed upon a compromise figure of 17,000.

(3) Calculations from the BACH MED 302 developed utilization rates for BACH. The utilization rates in visits per beneficiary per year were: active duty, 16; dependent of active duty, 8.4; retirees, 7.1; dependents of retirees, 6.1; others, 9.9. The rate for all (catchment area) beneficiaries was 10.5 visits per beneficiary per year. (The stated HMO rate is five visits per enrollee per year.) Although there are flaws using "visits" as

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on basis for utilization, it appears that BACH beneficiaries have adequate access to medical care.

(4) Table 1 was compiled from beneficiary data provided at the in-brief and staffing data from the BACH MC distribution worksheet. Under their health care plan, division assets at TMCs will care for active duty beneficiaries. Family Practice has "empaneled" 15,800 members, divided among non-active duty beneficiaries. Nine family practice physicians and a HCA care for these beneficiaries.

TABLE 1			
BENEFICIARY CATEGORY	TOTAL	"REGISTERED" FAMILY PRACTICE	"UNREGISTERED"
ACTIVE DUTY	24,095		24,095
AD DEPENDENTS	33,000	13,300 (30%)	19,700
Pediatric (est)	18,000	8,400	9,600
Adult (est)	15,000	4,900	10,100
RETIREEES/OTHERS	17,000	2,500 (13%)	14,500
PROVIDERS NEEDED:		9	19.5
Patients per Provider:		1750	1750
Type of Provider:		9 FP 1 HCA	5 FP (contract) 3 (of 5) PED 3 (of 5) IM 3 (of 5) GMO 3 (of 5) OB Nurse Pract Midwives

(5) Table 1 shows the remaining non-active duty population in the BACH catchment area to be 24,200 beneficiaries. Assuming 1,750 patients per provider and 100% empanelment, a total of 19.5 primary care providers can manage this population. The BACH plans to hire five family practitioners from funds recouped from terminating pediatric and general medical partnerships (\$1M). Adding those providers to 60% of the pediatric, internal medicine, general medical, and OB assets will total 17 of the 19.5

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"required" providers. Nurse practitioners, nurse midwives, or the remaining staff of pediatricians or general medical officers could supply the 2.5 provider difference.

(6) It is noteworthy that BACH has two family practitioners who are not included among the above nine empaneled FPs. One is the Chief, Department of Primary Care and Community Medicine, who is nearly a full-time administrator and the other staffs the Aviation TMC, seeing active duty and a few dependents.

(7) Bottom Line: There is sufficient staff to fully empanel the catchment area population with BACH providers. Hiring ancillary support to include ICAs will make these providers more effective. Moreover, health care finders, a specific phone number for appointments and advice lines, specific named providers for individual beneficiaries (primary care case managers), etc., will mimic the services presently available at the family practice clinic. These features should lessen the perception of dichotomy of care that exists among the installation population.

c. CCO.

(1) The purpose of the trip was to evaluate effectiveness and use of the contracted providers. These included contracts for the following services.

1 FTE Radiology

(Sterling Medical Associates, DADA10-91-D-0015)

2 FTE Social Worker Therapists

(PHP Healthcare, DADA10-90-C-0032)

2 FTE Master's Level Social Workers

(PHP Healthcare, DADA10-92-C-0009)

3 FTE Emergency Room (ER) Physicians

(NES Government Services, DADA10-90-D-0009)

(2) Contracted services are being provided in a timely and effective manner in meeting the hospital mission. MAJ Benjamin D'Ooge, ER Chief, provided information regarding the ER physicians, including statistics regarding the number of visits by provider (sampled the month of October as well as the corresponding work schedule). This compares very favorably with the workload of the staff physicians. A review of his records revealed he is monitoring the quality requirements, as physicians have been

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replaced during the period of the contract, a direct result of his oversight. He stated that he is happy with the physicians currently being provided by the contractor.

(3) MAJ Michael Spradlin, Chief of Psychiatry, discussed the social worker contractor with 1LT Robert Hughes, the new Contracting Officer's Representative (COR). He stated they have one civilian social worker who primarily does initial intake interviews while the contracted social workers do the actual counseling. He expressed his concern that centralizing the duties of the COR would be adding another layer of bureaucracy since he will still be required to provide all technical inspections and advice, although he recognized what was to be accomplished. He also emphasized to 1LT Hughes that the social worker contract money should be flagged as separate "fenced" money which supports the Family Advocacy Program, "counting neither for nor against the hospital's budget." The COR responsibilities were discussed with the newly assigned COR, 1LT Hughes. It is strongly recommended that he be sent to COR training in order to be able to fulfill his responsibilities as COR.

(4) Of the five radiologists on staff, one is the contracted radiologist, who is consistently providing services in accordance with the terms of the contract. However, the new COR (SSG Imoto) did not have a system in place which could evaluate workload.

5. RECOMMENDATIONS.

a. Fort Campbell MEDDAC withdraw the coordinated care plan initiative for a PRIMUS clinic as its only primary care expansion proposal.

b. Fort Campbell MEDDAC submit a new proposal to expand primary care based upon the DCSCS (Ambulatory Care Division) recommendations in this report (paragraph 4d).


c. Fort Campbell MEDDAC begin using the AQCESS CAM module for enrollment (paragraph 4c(2)).

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d. Fort Campbell MEDDAC send 1LT Robert Hughes to COR school
(paragraph 4e(3)).

4 Encls



HENRY C. BEUMLER
COL, MS
Team Chief

**LIST OF ATTENDERS - FORT CAMPBELL, KY
19-20 NOVEMBER 1992**

STAFF MEMBERS FROM MEDDAC, FORT CAMPBELL, KY

COL Stephen Xenakis, Commander
COL Dennis Leahy, Deputy Commander for Administration
COL Jo Ellen Vautta, Chief, Department of Nursing
COL Elise Roy, Chief, Nursing Administration Days
LTC Maureen Connors Potter, Chief, Coordinated Care Division
LTC Susan Vairin, Nursing Methods Analyst
LTC Glenn Simpson, Chief, Clinical Support Division
LTC Dale Schoonover, Chief, Troop Medical Clinic 5
LTC Jo Ann Dunsmore, Chief, Ambulatory Nursing Service
MAJ Larry Link, Deputy Chief, Coordinated Care Division
MAJ William Kocisak, Chief, Resource Management Division
MAJ Cynthia Davis, Chief, Patient Administration Division
MAJ Kenneth Franklin, Division Surgeon
MAJ Wayne Goggins, Division Physician Assistant
MAJ Peter Silkowski, Chief, Department of Primary Care and Community Medicine
MAJ Michael Spradlin, Chief of Psychiatry
MAJ Benjamin D'Ooge, Chief, Emergency Room
CPT Michael Ellerbe, Chief, Information Management Division
CPT James Lineburger, Admin Resident
1LT Robert Hughes, Contracting Officer's Representative
SSG Imoto, NCOIC, Radiology
Mary McCorkle, GS-11, Chief, Coordinated Care Branch
Murray Dale Watts, GS-9, Public Affairs Officer
Carol Braden, Civilian, CHAMPUS Select Fiscal Intermediary
Judy Beard, Coordinated Care Branch

STAFF MEMBERS FROM FORT CAMPBELL, KY

MG John Miller, Division Commander
BG Thomas Konitzer, Assistant Division Commander (Support)

STAFF MEMBERS FROM HQ, U.S. ARMY HEALTH SERVICES COMMAND

COL Henry C. Beumler, Chief, Coordinated Care Division
COL William H. Parry, Chief, Ambulatory Care Division
MAJ Keith W. Gallagher, Ambulatory Care Division
MAJ Gordon Jaehne, Resource Management Division
Jim Onks, GM-13, Health Care Management Engineering Activity
Gerald Jendrusch, GS-12, Resource Management Division
Edward A. Mazac, GS-12, Information Management Division
Lydia Barnea, GM-12, Central Contracting Office
Janice K. Leaders, GS-11, Information Management Division

Encl 1

HSXD-DCS

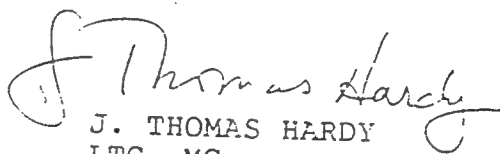
26 January 1993

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Multi-Specialty Clinic Process Action Team

1. The most critical piece of a managed care program (like Gateway to Care) is enrolling the beneficiary population, assessing their health needs, and assigning them to a health care team which can effectively meet their needs.
2. Over the course of the next 6-12 months, Blanchfield will move toward developing a number of these multi-disciplinary health care teams consisting of Family Physicians, Pediatricians, Physician's Assistants, Nurse Practitioners, Midwives, and the necessary ancillary support. These teams will be devoted to providing primary health care to active duty family members and those retirees who elect to enroll in our Gateway to Care program.
3. Similar multi-specialty teams have already been developed at the Fort Polk and Fort Riley MEDDACs and we will visit at least one of those sites as we develop our team concept.
4. Members of the process action team have been selected to represent those areas of our operation most effected by this reorganization. However, the list is certainly not all inclusive and I anticipate hospital-wide participation in this project.
5. This project will have a major impact on the way we are organized, do business and care for patients. It is our most significant initiative since embarking on Gateway to Care and I need your complete support in order to pull it off. The team will meet at 1000 sharp in the Executive Conference Room the second and fourth Friday of each month. Please block out this time on your calendar each month and tighten your chin straps. We will have our first meeting at 1000 on 12 February 1993. See you there!

Encl



J. THOMAS HARDY
LTC, MC
Deputy Commander for Clinical
Services

DISTRIBUTION:
See Enclosed List

MULTI-SPECIALTY CLINIC PROCESS ACTION TEAM

DEPARTMENT OF MEDICINE
DPCCM
FAMILY PRACTICE
HEAD NURSE, FAMILY PRACTICE
PEDIATRICS
HEAD NURSE, PEDIATRICS
ADMIN RESIDENT
C, AMB NURSE
C, MIDWIFE
HEAD NURSE, OB
C, DON
CSD
CCD

IMO
PAO
PAS
PAD

DR. COLLINS
DR. SILKOWSKI
DR. BARTHEL
MRS. GRAY
DR. PAPA
CPT(P) NEWMAN
CPT LINEBERGER
LTC DUNSMORE & NCOIC
MAJ GRAY-ROZIER
LTC NADER
COL VANATTA
LTC SIMPSON, G.
LTC POTTER/MAJ LINK/MARY
MCCORKLE/KIM MATTHEWS
CPT ELLERBEE
MURRAY D.. WATTS
MRS. CONLEY
~~MAJ ANCKER~~ *Cot Reed*

Exhibit C

PRIMARY CARE CLINIC PROCESS ACTION TEAM

COL Brown	Cdr _____
LTC Hardy	DCCS _____
COL Leahy	DCA _____
LTC Collins, L.C.	C, DOM _____
MAJ Silkowski	C, DPCCM _____
MAJ Barthel	C, FPC _____
Mrs. Gray	Head Nurse, FPC _____
CPT Lineberger	Admin Resident _____
LTC Dunsmore	C, Amb Nursing _____
SGT Holmes	NCOIC, Amb Nursing _____
MAJ Gray-Rozier	C, Midwife _____
CPT Haig	Head Nurse, OB _____
LTC Nader	Maternal Child Care _____
COL Vanatta	C, DON _____
LTC Simpson, G.	C, CSD _____
LTC Potter	C, CCD _____
Ms. Matthews	Health Risk Appraisal Nurse _____
CPT Ellerbee	C, IMO _____
Ms. Conley	C, PAS _____
LTC Vairin	NMA _____
MAJ Link	CCD _____
MAJ Ancker	C, PAD _____
Mr. Mumford	Logistics _____
Ms. Morris	C, QI _____
LTC Heidenheim	Chief, Logistics _____

Ms. Stewart
SFC Morgan
MAJ Kociazak
Ms. Shepherd
Ms. Chaffins
Ms. Watts
CPT Newman
LTC Papa

Logistics _____
DON _____
C, RMD _____
Secretary, DOM _____
Secretary, DCCS _____
PAO _____
Peds _____
Peds _____

Multi-Specialty Clinic DFT

12 Feb 93

All family members, some retirees. Link them with a clinic, not a specific provider.

Hospital will affirm responsibility to care for a panel of patients to one clinic.

Accomplish by ~~1000~~ 1 Oct 93

Space Studies: Closed 9AA because of workload.
Opened up space to move psych/social work.

Multi-specialty clinic areas will be Family Practice, Current psych/social work, and current PEDS.

Team (Clinic) Composition

providers

Family Practice Physician
Pediatrician
GMO
NPs
PAs

ancillary

Advice Nurse
Receptionist
HCO
Nurse
Nurse Aide
Appointment Clerk

Active Duty Family Members
Retirees currently in FP
Retirees w/children ↓ 14

After the clinics are operation, many retirees will still be out there.

Rde of OB docs & nurse midwives is unclear at this point.

Rde of EFMP & pediatric specialists. Need to keep them separate as referral services. Keep a separate pediatric consultant service.

Communications will remain as a problem. Giving priority to receptionists & advice nurses.

How to handle on-call and inpatient ~~responsibilities~~ responsibilities.

Internists inclusion in the panel? Right now they're not included. Make them a single-specialty panel?

Training of personnel who will be dealing with people of different ages than they are currently dealing with.

MEPS

Enrollment / registration

Home self-care program

No increase in personnel

Separate to ~~SEPP~~ resources for special needs, E/D, E/M
maintain relationships with campus pediatric specialists
(neurologist, orthopedist, cardiologist).

model for clinics -

Milestones

- 1) * seeing patients by 1 Oct 93.
- 2) By 1 June 93:
- 3) Funding for FY 94 -- Budget is a problem.
Goal is to shift people around, not to necessarily
@ hire new people.

(FP clinic)

RED TEAM

9-10 providers	8662 AD Dep
	1633 Ret (FP)
	<u>1000</u> Ret (w/kids)
	11,255

(psych/soc.wk.)

WHITE TEAM

11-12 providers	10,592 AD Dep
	1,633 Ret (FP)
	<u>1,000</u> Ret (w/kids)
	13,255

(pets clinic)

BLUE TEAM

12-13 providers	11,500 AD Dep
	1,633 Ret (FP)
	<u>1,000</u> Ret (w/kids)
	14,133
38,613	Multi-spec. clinic
4500	Ent. med.
<u>8887</u>	OPC
50,000	

119
Peds docs
PAs
NPs
AMOs

Peds & OB/GYN will become consultative services.

NPs will move out of OB/GYN. Midwives & OB docs will stay.

2. Needs assessment for Peds - LTC Collins

- 1) who are the pts - type & #
- 2) who are the providers
- 3) what is their space requirement?

1. Space evaluation for peds + OB - LTC Varnen
- CMPS → TMC #5
→ HCO club

- 3.) Nursing assets to MSC - Col Varatta + LTC Dunsmore
- 1) Who
 - 2) Where to assign
 - 3) No more dependents at TMC + S → shift to one of the clinics, as is OPC + OB Clinic.
 - 4) Ideally, have 2 exam rooms + 1 assistant (chaperone) per provider.

- 4.) ESD assets to MSC - LTC Simpson + I
- 1) Different from DPCCM
 - 2) schedules
 - 3) appointments
 - 3) call schedule

- 5) psychosocial work to FAA - LTC Hardy + LTC Simpson

- 6) Liaison to Union + CPD - COL Leahy, Judy Beard, LTC Warner

7.) OPC to Sterling

8.) Hiring actions (3 MPs) - LTC Potter

9.) Partners to Contracts ^{2 Peds}
1 MP - LTC Potter

10.) Continuity of Care - LTC Potter
Hours - call - continuity of mpt care

- SE will be downsized with Staffing.
- Look at evening clinic hours
- Must consider all hours of operation in all ~~the~~ areas. Look at flexing hours to avoid ↑ in SE utilization among those in AMIC on teams.
- Don't plan to eliminate the evening clinic in Peds.
look

Other Concerns

Telephone Equipment

- AED maximum utilization in all appointment clerk areas.
- (1) Additional telephone in each area for a floater to use during peak times.

Computers

- (1) Additional computer terminal to use in each area for floaters.

Provider Interaction

Centralizing vs. decentralizing

PROS + CONS

- ① ~~If supervision is given to clinic does what will happen if 1-deer and people go on leave? covering will be difficult if using clinic assets.~~
- ② Who will do physicals? How will we appoint them?
School Physicals?
- ③ Letter input for appraisals: Required by 40-5
- ④ Need to have a contract scheduler to handle the OPC only. Cont appoint to OPC from multispecialty clinics

- Have some preliminary data in 2 weeks.
- Break out a portion of CMPS to somewhere outside the facility.
 - physical exam
 - inprocessing
- OB/MID WIFE \Rightarrow no change to relationship
- Communications issues not addressed
- ancillary nursing support
- use of health care extenders
- Call & inpatient responsibilities
- internists not included in clinics.
 - will provide care for their own pts & will also see the MSC pts on a referral basis.
- People not enrolled will go to the OPC.
- Transients must be seen somewhere \Rightarrow OPC?
 - ER?
 - TMC#5?

What's left? 12-13,000 retirees. How to handle this? Screen med records & take 4500 sickest & oldest & put in Internal Medicine. Other ~~9,000~~ 9,000 will go to the Outpatient Clinic which will become a completely Sterling (campus partner), fee-for-service clinic. Goal is to move this to a capitated contract clinic.

We have the low numbers of providers already.

Issues

1. Space ~~eval~~ evaluation for Peds & OB EIP, EFMP & LTC Paper
2. Needs assessment for special needs peds clinic
3. Nursing assets to MSC
4. CSD assets to MSC
5. Psych/social work to 4AA
6. Liaison w union & CPO
7. OPC to Sterling
8. Hiring actions (3 MPOs)
9. Partners to contract 2 peds
1 NP
10. Enrollment

CMPS
Middle School / Exams
Mr. Legare
Physical Exams

1. The first part of the document is a list of names and addresses, which appears to be a directory or a list of contacts. The names are written in a cursive script, and the addresses are listed below them.

BLUE CLIMIC (2)

WHITE
CLINIC
(P205)
(2)

RED
CLINIC
(FP)
(2)

- Normal UA
- Pap smears
- Birth control
- no same day sick

OPC
Sterling Personnel
(0)

OPC - sterling

(7) FITTED

breeding
physical trans-
fat med

47
00/044

- High B5KOB
- Mumps OB
- Displasia Clinic
- Infertility

TMC5
-0-

FFD

- Same
- + Dr. Pagan

11/23/25

40T
SUPER.

MEMORANDUM FOR Multi-Specialty Clinic Process Action Team

SUBJECT: Issue of Clinical Support Division Support of the Multi-Specialty Clinics

General. At the Process Action Team (PAT) meeting on 26 February, I was tasked, along with Ms. Sue Conley, Supervisor of the Patient Appointment System, to explore the issue of providing support from the Clinical Support Division (specifically the Patient Appointment System) to the proposed Multi-Specialty Clinics.

Background.

1. The current appointment system is decentralized to the various clinics. The appointment clerks working in primary care areas (Outpatient Clinic, Pediatrics, Family Practice, Obstetrics/Gynecology, Internal Medicine) are supervised by Ms. Conley, and are assigned to the Clinical Support Division. These clerks generally have appointing and scheduling as a primary duty (see enclosure 1).

2. Appointments for the other referral and specialty clinics are made by clinic personnel as an additional duty. These clerks generally work for the Departments of Nursing, Surgery, Medicine, or Psychiatry (see enclosure 2).

Recommendations.

1. Assignment of Clerks:

a. Pediatric Clinic (2 clerks): Both of these clerks would move to one of the new clinics. If some sort of "Pediatric Consultation Service" remains, then the administrative staff put in place to support this service would also have the responsibility of appointing and scheduling.

b. Obstetrics/Gynecology Clinic (2 clerks): Both of these clerks would stay at the OB/GYN clinic to provide appointing and scheduling services for the physicians and nurse midwives who would remain at the clinic.

c. Family Practice Clinic (2 clerks): Both of these clerks would stay at the Family Practice Clinic as it converts to one of the new clinics.

d. CMPS (2 clerks): The clerks currently in CMPS would move to one of the new clinics. The scheduling they currently do for the Outpatient Clinic would have to be picked up by a contract clerk hired by Sterling when the OPC converts to an "all Sterling" operation. Physical exams (Mr. Lepage) would be scheduled by the Internal Medicine Clinic appointment/scheduling clerk. Appointments for school physicals would be made by each of the new clinic clerks. All physicals would continue to be done in the CMPS area.

HSXD

SUBJECT: Issue of Clinical Support Division Support of the Multi-Specialty Clinics

e. Internal Medicine Clinic (1 clerk): The clerk currently in the IMC would stay in place. He would also pick up the responsibility for scheduling physical exams for Mr. Lepage in the Physical Exam Section.

2. **Structure and Staffing of Patient Appointment Service (PAS):** Recommend the PAS remain a section within the Clinical Support Division (CSD). The PAS supervisor, lead clerk, and the actual number of clerks will not change. As noted above, however, a realignment of scheduling responsibilities will occur.

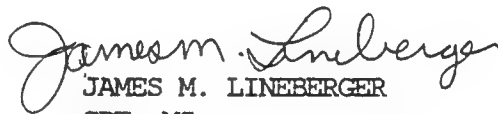
3. **Supervision of Clerks:** The clerks should continue to be supervised by Ms. Conley. She alone has the experience and knowledge to provide education and training for the clerks. In addition, by retaining the clerks under her supervision, she can more efficiently maintain clerk staffing in all areas when the clerks are on leave, sick, etc.

4. **Centralized vs. Decentralized:** Recommend the clerks physically work in the clinic for which they appoint/schedule patients. This decentralization enables better coordination between the clinic and scheduling clerk, and also encourages a positive relationship among the clerks, patients, and clinic providers and staff. Some level of centralization can occur through consolidated supervision (Ms. Conley), and by increasing the use of automation (computer networks) and communications systems (automatic call distribution).

5. **Communications and Automation Equipment:** To maximize the use of the floaters currently available to Ms. Conley, recommend an additional telephone and computer be installed in each of the new clinics. This would allow up to three clerks to be working in the clinic simultaneously during peak demand periods. Additionally, the hospital's Automatic Call Distribution (ACD) system must be configured to provide the best support to the appointment clerks.

Summary. The PAS can support the new clinic concept will relatively little change from current operations. Additional consideration to equipment upgrades and maximized use of available communications technology will make the new system better than the current one.

Encl


JAMES M. LINEBERGER
CPT, MS
Administrative Resident

Enclosure 1 - Current System - CSD Clerks

Clinical Support Division Appointment Clerks

* Directly supervised by Ms. Conley.

* Have appointing and scheduling as their primary duty.

1. Consolidated Medical Processing Station (CMPS): Two Clerks

Appoint patients for the Outpatient Clinic and Physical Exam (Retirement Physicals, School Physicals, etc.)

2. Pediatric Clinic: Two Clerks

Appoint patients for well baby, same day sick, follow-ups.

3. Family Practice Clinic: Two Clerks

Appoint patients for well baby, same day sick (adult and peds), obstetrics, gynecology.

4. Internal Medicine Clinic: One Clerk

Appoint patients for internal medicine and also maintains the waiting list for dermatology.

5. Obstetrics/Gynecology: Two Clerks

Appoint patients for infertility, dysplasia, routine obstetrics, gynecology

In addition there are two temporary floaters and one permanent floater who fill in for the above clerks when they are sick, on leave, etc.

Other Appointment Clerks

* Not supervised directly by Ms. Conley. She has letter input into their appraisals.

* Perform appointing and scheduling as an additional duty.

1. **Medical Specialty Clinic:** Three clerks, two from Department of Nursing and one from Department of Medicine. Appoint patients for allergy, dermatology, and neurology.

2. **Urology Clinic:** One clerk from the Department of Nursing who appoints for urology.

3. **Surgery Clinic:** One clerk from the Department of Nursing who appoints patients for surgery.

4. **Troop Medical Clinic #5:** One clerk from the Department of Nursing who appoints Division Optometry and some family appointments at the TMC.

5. **Ear, Nose and Throat (ENT) Clinic:** One clerk from Department of Surgery who appoints patients for ENT and speech rehabilitation.

6. **Ophthalmology/Optometry:** Two clerks from the Department of Surgery who appoint patients for ophthalmology, optometry and audiology.

7. **Occupational Therapy:** One clerk from the Department of Surgery who appoints for occupational therapy.

8. **Orthopedic Clinic:** Two clerks from the Department of Surgery who appoint for orthopedics.

9. **Podiatry Clinic:** One clerk from the Department of Surgery who appoints for podiatry.

10. **Physical Therapy Clinic:** Two clerks from the Department of Surgery who appoint for PT.

11. **Psychiatry Clinic:** One clerk from Department of Psychiatry who appoints patients for psychiatry.

12. **Exceptional Family Member Program:** Two clerks who work solely for EFMP (DoD "fenced" resources) who appoint for EFMP.

Exhibit G

MULTI-SPECIALTY CLINIC PROCESS ACTION TEAM MEETING
AGENDA

I. OLD BUSINESS

- A. SPACE ISSUES - LTC VAIRIN
- B. NEEDS ASSESSMENT FOR SPECIAL PEDS - LTC COLLINS *750 to 1000 kids
140 spec clinic - encompassed
in one of new clinics.*
- C. NURSING ASSETS TO MSC - LTC DUNSMORE
- D. CSD ASSETS TO MSC - LTC SIMPSON *- MAF Silkauci - LTC Dunsmore*
- E. MOVE OF SWS TO 4AA - LTC SIMPSON
- F. LIAISON WITH UNION AND CPO - COL LEAHY
- G. OPC TO STERLING/CONTRACT - CCD *contract to begin 1 OCT 93.*
- H. HIRING ACTIONS (NP'S) - CCD
- I. PARTNERS TO CONTRACT - CCD
- J. ENROLLMENT - CCD

II. NEW BUSINESS

A. WHAT MISSIONS NOW BEING DONE BY FP, PEDS, AND OB NP
WILL HAVE TO BE REDISTRIBUTED?

- 1. FACMT SCREENING
- 2. SPECIALTY CONSULTATION
- 3. SCHOOL PHYSICALS - *all clinics appoint; work done in physical exam.*
- 4. IMMUNIZATIONS - *each clinic*
- 5. WELL-BABY CHECKS - *even clinic*
- 6. EFMP SCREENING - *even clinic*
- 7. SPECIAL NEEDS CARE
- 8. CONSULTATION

B. SPACE REQUIREMENTS

C. PHONE ACCESS BY PATIENTS TO MSC, APPOINTMENTS, ETC. *Lease
17 more #S.*

D. HOW/WHEN SHOULD WE PLAN TO MOVE

- 1. HOW LONG WILL IT TAKE
- 2. HSSC INVOLVEMENT

E. Brief Staff about our plans

- Physicians
- Nurses
- Civilians
- Administrative/ancillary staff

Exhibit H

Primary Care Clinic IPR
21 April 1993

1. Personnel: Enclosure 1 lists the current staffing assignments. Minor changes will occur throughout the planning process to meet both organizational and personal needs.
2. Space/Physical Plant: The clinic areas are being thoroughly evaluated for final assignment of space. Minor physical plant modifications may be necessary (i.e., installation of several sinks, a drywall partition may be needed in PCC #2). Final determination will be made by 30 April.
3. Communication and Automation: Telephone and automation requirements are very close to being finalized - based on space assignments.
4. Equipment: Line item lists are being prepared now; will be complete as space assignments are refined and finalized by 30 Apr 93.
5. Administrative: List of major issues is at Enclosure 2.
6. C³ - Command, Control, Coordination: Weekly meetings with team leadership (Clinic Chiefs, HN's, NCOIC's, C, ANS, Dr. Papa, C, ACSB, Admin Resident) in addition to biweekly PAT.

2 Encls

MAJ SILKOWSKI

Administrative Issues

1. Policies for appointments
2. Policies for triage
3. Policies for admission and call
4. Policies for rounds
5. Policies for panel coverage and prescription refills
6. Policies for meetings
7. Policies for QI
8. Central versus decentralized appointment system
9. Appointments - cross book ?
10. Assignment of OB patients - CNM, FP, HROB, etc.
11. Retiree pregnancies
12. Impanelment - HRA, publicity
13. Sterling Partnership OPC - C³, QI
14. Reorganization of DPCCM - HSC Reg 10-1, para 3-2(11), 3-3, and 3-7
15. Patient education services - use of advice nurses, handouts, newsletter
16. Active duty PAPS (1650 x 135 from MEDDAC/DENTAC = 1785 total)
17. School physical examinations
18. CMPS - OIC and staff
19. TMC 4 and 5 sick call coverage
20. Hospital signs
21. Clinic names
22. BACH phone book and directory
23. Civilian personnel issues
24. Peds unique issues

Enclosure 2

Exhibit I

move of 3AC to 4AA.

move of OB Clinic to 3AC

Cost of everything involved with move to be done by end of April. Equipment requisitions a priority.

Enrollment: Have broken people down into how they will be empaneled.

Next meeting

- ① Equipment costs
- ② Move
- ③ Enrollment

Primary Care Clinics

6 May 1993

1. SPACE - Work orders
 - Appointment clerks (centralized vs. decentralized)
 - Security, privacy
2. EQUIPMENT -
3. COMMO/AUTOMATION -
4. ADMINISTRATION - Unit assignment up-date
 - Advice nurses (role, centralized vs. decentralized)
 - Time Line?
 - Sit Rep
 - Appointments - Cross book
 - Policies for appointments
 - Policies for triage
 - Policies for admission and call
 - Policies for rounds
 - Policies for panel coverage and Rx refills *divided into 2 parts*
 - Policies for meetings, Quality Improvement
 - Logo
5. COMMENTS BY MEMBERS.

1600 - 6 May 93

Centralized vs. decentralized \Rightarrow non-negotiable

Need to expand the role of the appointment clerks to take messages for physicians after all of the appointments have been booked.

What does the app. clerk's job description look like?

Advice Nurses

roles: Triage, information

- Centralized or Decentralized.

PRO

CON

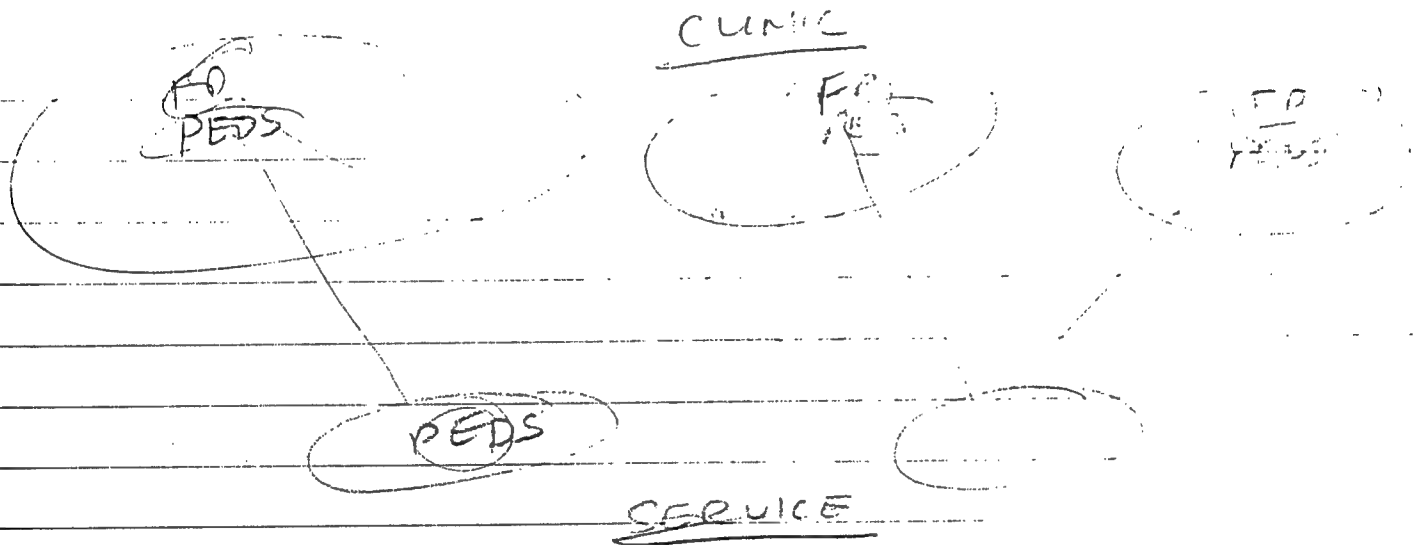
- loss of team concept

- who manages pts. after app'ts. are full?

- Advice nurses not trained in other areas. Feel uncomfortable giving advice.

Call Gloria to find out what is going on re the PERT CHARTING.

QAI = must have meetings by clinic. Also need to have SERVICE specific mts.



Think of Logos

Need to document what is happening...

Annexes

1. Marketing Plan ~~External~~

2. Time line With milestones

3. Staffing & Personnel

a. Union • CPO

b. Partners to contract

→ organization
chart; rating schemas

4. Equipment Requirements

5. Clinic Layouts

6. Budget & Costs

7. Enrollment & Clinic Assignment

8. Communications

9. Automation

10. Impact on other operations

a. OPC

d. EFMP

b. OB/GYN

e. EIP

c. PEDS

f. TMCs

11. Staff Education

a. Nursing

b. Physician

c. Ancillary

Operating Costs

↓ in ER visits saves \$\$

↓ in OPC visits saves \$\$

Basically adding (2) Clinics -- operating cost equivalent to two "new" FP Clinics, less what was seen previously in PEDS + OB/GYN.

OB/GYN & PEDS Clinic will continue to operate & have costs.

① Get current costs for FP, OB/GYN & PEDS Clinics.

② Ave cost per visit in ER.

③ Ave cost per OPC visit.

- Introduction -- tie into current access situation, community needs, accountable medical care...

- Get things down on paper -- document process.

- Identify all tasks; categorize as - major & minor

- critical & non-critical

- related & unrelated

- measurable indicators showing our way of business is improved by doing this.

Compare old FP model with new primary care model. What is criteria? Dr. Bertnel's Study is one possibility.

- Post
- Quality
- Access
- Wellness (!)

PER visit rate
OPC visit rate
• CMI/severity of illness
staff & patient satisfaction surveys

- Bottom line differences between the way we now operate & the way we will operate in the future. Will it indeed be better? Prove it.

- "Business plan" type proposal

- Better control over appointments
- Responsibility / Accountability for a patient population.

Chief's Meeting

6 October 1993

Primary Care Clinic

Time Line: 30-31 October - OB/GYN Clinic and CNM's move to 3AC
 - Open 1 November

12-13-14 Nov - Reorganize Primary Care
 - Open 15 November
 - DONSA 12 Nov - Work Day for PCC staff et al.

What Changes: - Will have 3 Primary Care Clinics
 - Peds Clinic and FP Clinic will no longer EXIST
 (Peds and FP inpatient service is not affected)
 - Each clinic will have FP's, Peds, NP, PA's, GMO's
 - 3AC will be HROB, GYN consultation, CNM's
 - All routine OB (other than CNM patients) will be seen in
 Primary Care Clinics
 - Internal Medicine Clinic (Silver Clinic) - NO Change

What Patients are seen in Primary Care Clinics:

- All Active Duty Dependents (to include MEDDAC/DENTAC)
- Family Practice Retirees
- Retiree Dependents 13 and younger

PCC Locations & Staffing: See Attached

Phone & Appointments: - 40 Lines to PCC's
 - Automated Call Distribution
 - Phone number for any and all Primary Care Clinic
 Services HOSP (4677)

MEDDAC/DENTAC & Med Hold

Sick Call and Dependents: Clinic assignment based on last # of
 Sponsors SSN

0, 1, 2, 3 = Red Clinic
 4, 5, 6 = White Clinic
 7, 8, 9 = Blue Clinic

Miscellaneous: - Woman's Clinic
 - Labor & Delivery Coverage
 - Outpatient Clinic - All Sterling Partners
 - Marketing/Patient Education

1000

PRIMARY CARE CLINIC PLAN
ANNEX SUPPORT

<u>SUBJECT</u>	<u>RESPONSIBILITY</u>
MEDICAL EQUIPMENT STATION PROPERTY (Installation)	LTC HEIDENHEIM/ MAJ SILKOWSKI
HEALTH CARE PROVIDERS (DOCS, NPs, RPs)	LTC HARDY/LTC SIMPSON
ADMIN SUPPORT	LTC SIMPSON/ MAJ SILKOWSKI
ANCILLARY/NURSING SUPPORT	LTC DUNSMORE/ MAJ SILKOWSKI LTC SIMPSON
OUTPATIENT/EVENING/WEEKEND CLINIC	CCD/LTC HARDY
INTERNAL MEDICINE CLINIC	CCD/MAJ MCKNIGHT
OB/GYN/WELL WOMAN CLINIC MIDWIVES	CCD/SFC BOYLES/ ⁸¹⁴⁷ MAJ GRAY-ROZIER
PUBLICITY - STAFF EDUCATION: ADMIN. RES.	PAO/MAJ SILKOWSKI / CCD/CCD
MEDICAL EQUIPMENT	LTC HEIDENHEIM/ MAJ SILKOWSKI
STATION PROPERTY	LTC HEIDENHEIM/ MAJ SILKOWSKI
COMMUNICATIONS SUPPORT	CPT ELLERBE/ MAJ SILKOWSKI
COMPUTER SUPPORT	CPT ELLERBE/ MAJ SILKOWSKI

- SUMMARY OF COSTS
 - START UP 3-5 YEARS
 - OPERATING
- TIME LINE / IMPLEMENTATION SCHEDULE
- DETAILED DESCRIPTION OF SPACE?
- EVALUATION PLAN (Dr. Bartnef's study?)
- FACILITY MODIFICATION -



DEPARTMENT OF THE ARMY
HEADQUARTERS MEDICAL DEPARTMENT ACTIVITY
FORT CAMPBELL, KENTUCKY 42223-1498

Exhibit M



REPLY TO
ATTENTION OF:

25 October 1993

PRIMARY CARE REORGANIZATION

1. November is the month for change and reorganization at Blanchfield Army Community Hospital. The Family Practice Clinic, the Pediatric Clinic, and part of the OB-GYN Clinic will reorganize resulting in three Primary Care Clinics that will provide full service primary care.
2. Active duty dependents are assigned to either the Red, White, or Blue Clinic based on the sponsor's military unit, or in some cases, the last number of the sponsor's social security number. Retiree children ages 13 and under are assigned based on the last number of the sponsor's social security number. See the attached "Primary Care Clinic Assignment Sheet" for your clinic assignment. Retiree families enrolled in the former Family Practice Clinic will be assigned to the clinic where their current family doctor will be working. Clinic assignment information for family practice retirees is available in the Family Practice Clinic until 10 Nov 93 and each primary clinic after 15 Nov 93.
3. On 1 November 1993, the current OB-GYN Clinic (which consists of routine OB, high risk OB, Midwife Service, Gynecology consultations, and OB/GYN walk-ins) will move to Ward 3AC. On 15 November 1993, the Family Practice Clinic will become the White Clinic, the Pediatric Clinic will become the Red Clinic, and the "old" OB/GYN Clinic will become the Blue Clinic. Also on 15 November 1993, the Routine OB Clinic will become part of the Red, White and Blue Clinics and routine OB patients will receive their prenatal care in their assigned primary clinic. The OB/GYN walk-in clinic ceases on 15 Nov and patients will be seen on a same-day appointment basis in their assigned primary clinic.
4. The Exceptional Family Member Program (EFMP) and special pediatrics (LTC Papa and Pediatric Cardiology and Neurology) will move to the Blue Clinic; their phone numbers and clinic procedures are unchanged. The Outpatient Clinic will continue to provide primary care for CHAMPUS eligible retirees and retiree dependents age 14 - 65. Medicare eligible retirees will be seen by a non-CHAMPUS provider, when available, in the Outpatient Clinic. If appointments are not available in the Outpatient Clinic, a Health Care Finder will assist retirees and retiree dependents. The Health Care Finder number is 502-798-8280.

5. The telephone system supporting the new primary clinics will also undergo improvements. An automated call distribution system will be in place and, with the use of a touch-tone telephone, will allow access to the primary clinics for appointments, messages, prescription refills, lab results and the advice nurse. All three primary clinics can be reached by calling the same telephone number. Patients calling from on Post will use 798-HOSP(4677) and those calling from off Post will use 431-HOSP(4677). The new phone system will be operational at 0730 hours 15 November 1993.

6. The changes as described above do not allow the scheduling of routine and follow-up appointments in the Primary Care Clinics prior to 15 November 1993. Patients wanting routine and follow-up appointments should call their clinic after 1300 hours each day starting on 15 Nov 93. There will be adequate same-day appointments available each day for those patients needing same-day medical care. The primary clinics will not have a walk-in service; all patients must have appointments and should call to obtain one of the same-day appointments.

7. The reorganization of these clinics will realign resources with the sole intent of improving services to BACH patients. There will likely be some initial inconvenience as we refine our operations and your patience and understanding are appreciated. Your feedback and suggestions are always welcome.

Primary Care Clinics

	Blue Clinic Old OB Clinic	Red Clinic Old Peds Clinic	White Clinic Old FP Clinic
FP	Dr. Barthel - Chief Dr. Norris Dr. Blanke TBA	Dr. Sherrill - Chief Dr. West Dr. Willett Dr. Lehman	Dr. Kasper - Chief Dr. Stein Dr. Soyke Dr. O'Brien
Ped	Dr. Curtin Dr. Goldbach Dr. Papa Dr. Fisher - EFMP	Dr. Jones - Peds Sterling Peds	Dr. Watkins Sterling Peds
GMO	TBA Dr. Moore - GMO	Dr. Sitenga - GMO	Dr. English - GMO
PA	Mr. Knop TBA	Mr. Gilbert	Mr. Black
NP	MAJ Edwards (FP) Ms Matteson (OB)	MAJ Dubeck (Peds) LTC Prinkey (OB)	MAJ Allman (Peds) TBA
HN	MAJ Milford Ms. Gainer	Ms. Hale	Ms. Gray
WM	SSG Lindsey	SFC Blanton	SFC Reynolds
LPN	Ms. Metcalf Ms. Martin Ms. White	Ms. Short Ms. Knox TBA	Ms. McCullough Ms. Gregg Ms. Cadena
NA	Ms. Fentress PFC Alvarez SPC Williamson Ms. Myers SP4 O'Brien SP4 Henley PFC Figueroa	Ms. Smith Mr. Melton SP4 Fischer SPC Patterson Ms. Murray Ms. Barrios TBA	Ms. Reid Ms. Ashby Ms. May Ms. Hoffman PFC Graham SPC Salinas TBA
Clk	Ms. McMillen Ms. Wilson Ms. Morse	Ms. Smith Ms. Davis TBA	Ms. Crawford Ms. King Ms. Rivers
TCHA	Ms. Finnegan	Ms. Dillard	Ms. Humes
PAS	Ms. Brown Ms. Deering	Ms. Ellis Ms. Craddock	Ms. Lee Ms. Sleigh

Clinic Assignments for Dependents of Active Duty Soldiers
Based on Major Unit/Subordinate Units of Sponsor

1st BDE

1/327 INF - Red
2/327 INF - Red
3/327 INF - Red

2nd BDE

1/502 INF - Blue
2/502 INF - Blue
3/502 INF - Blue

3rd BDE

1/187 INF - White
2/187 INF - White
3/187 INF - White

DIVARTY

HHC DIVARTY - Blue
1/320th FA - Blue
2/320th FA - Blue
3/320th FA - Blue
5/8 FA - Blue
2nd FAD - Blue

AVN BDE

HHC
1/101st AVN - White
2/101st AVN - White
3/101st AVN - White
4/101st AVN - White
5/101st AVN - White
6/101st AVN - White
7/101st AVN - White
9/101st AVN - White
2/17 CAV - White

DISCOM

HHC
101st PSC - Blue
101st FIN - Blue
101st BAND - Blue
40 PA - Blue
50th MED CO - Blue
159th AVN - Blue
8/101st AVN - Blue
626 FSB - Blue
526 FSB - Blue
426 FSB - Blue
801st MAINT - Blue
53rd QM - Blue
63rd CHEM - Blue
140th OD - Blue
291st CS - Blue
79th CS - Blue

LEC/PMO

HHC LEC - White
101st MP - White
194th MP - White

101st SG(C)

132nd CS - Red
95th MAINT - Blue
114th ENGR - Red
129th CSB - Red
390th TRANS - Red
227th GS CO - Red
494th TRANS - Red
372nd TRANS - Red
86th EVAC HOSP - Red
USAG - Red
101st CSG - Red
61st MED DET - Red
61st ENG DET - Red
83rd MED DET - Red
102nd QM - Red
541st TRANS - Red
561st S&S - Red
584th MAINT - Red
594th TRANS - Red
17th EOD - Red
41st ENGR - Red
20th REPL - Red
196th QM - Red
666 MED DET - Red
744 QM - Red
NCO ACADEMY - Red

326 ENGR

887 ENGR - Red

HHC 101st DIV

AIR ASSAULT SCHOOL - BLUE

AIR FORCE

DET 1/1st WG - Red
DET 5/18th ASG - Red

MEDDAC - Red, White, Blue

DENTAC - Red, White, Blue

5th SFG - White

44th ADA - Blue

1/58th AVN - White

160th SOAR - Red

311th MI - Blue

501st SIG - Red

529 ENG - Red

535th ENG - Red

902 MI - Blue

TRIAL DEFENSE - White

USAISC - Red

CID, (31st MP) - White

The people listed below are assigned to a clinic based on the last number of the sponsor's SSN as follows:

0, 1, 2, 3 = RED CLINIC
4, 5, 6 = WHITE CLINIC
7, 8, 9 = BLUE CLINIC

- MEDDAC/DENTAC/MEDICAL HOLD
Active Duty and Dependents
for Sick Call and
Appointments
- Dependents of Active Duty
NOT Assigned to FTCKY and
Live IN Gateway to Care
- Retiree Dependents 13 years
old and under.

Retiree Families enrolled in former Family Practice
Clinic will follow current Family Practice Doctor

ACTIVE DUTY

PRIMARY CARE SITE

Active Duty (Assigned to FTCKY)----- - TMC'S
 ----- - MEDDAC/DENTAC/MED HOLD to PCC's

Active Duty (Not FTCKY)----- - TMC #5 for Sick Call

Reserve & National Guard----- - If fulltime AD --> TMC #5

Active Duty For Training----- - TMC of Sponsoring Unit

Active Duty Female Routine PAPs----- - TMC's (By Appointment)

Active Duty Female Vaginitis----- - TMC's (Sick Call)

Active Duty Pregnant----- - PCC's Based on Unit Assignment
 ----- - Midwife if space Available

ACTIVE DUTY DEPENDENTS

Sponsor Assigned to FTCKY----- - PCC's Based on Sponsor's
 Military Unit Assignment

Sponsor NOT Assigned to FTCKY,
 But Dependents Live IN Gateway to
 Care Area----- - PCC's Based on Last # of
 Sponsor's SSN

Sponsor NOT Assigned to FTCKY
 And Dependents Live OUTSIDE
 Gateway to Care Area----- - Champus, PPO for Routine Care,
 Emergency Center for Urgent Care

RETIREEES AND THEIR DEPENDENTS

Retirees and their Dependents
 Formerly Impaneled in Family
 Practice----- - PCC's (Will Follow their Current
 Family Practice Doctor)

Retiree Dependents Under age 14
 That Live In Gateway to Care Area-- - PCC's Based on Sponsor's SSN

That Live Outside GTC Area----- - Champus, PPO, PCC's on Space
 Available Basis

Retirees and their Dependents Age 14
 through 65 That Live IN Gateway to
 Care Area
 - General Medicine----- - Outpatient Clinic
 - GYN----- - Woman's Clinic or OPC
 - Prenatal/OB Care----- - Midwife Service

That Live Outside GTC Area----- - CHAMPUS, PPO, PCC's on Space
 Available Basis

Retirees and their Dependents age 65
 And Older (Medicare Eligible)

That Live in GTC Area----- - OPC if providers Available, PPO,
 IMC (only if enrolled).

That Live Outside GTC Area----- - Provider of Choice, IMC (only if
 enrolled), Outpatient Clinic if
 Providers Available.

PCC = Primary Care Clinic
 PPO = Preferred Provider Organization

PRIMARY CARE CLINICS SPACE ISSUES

PURPOSE: To examine space within the facility and determine which areas would be most appropriate for the Red, White, and Blue Primary Care Clinics.

DISCUSSION: The proposed composition of the health care providers is a combination of physicians, nurse practitioners, physician assistants and the support ancillary and administrative staff.

RED TEAM - Current Family Practice area (10 Providers)

8662 AD Dep.
1633 Ret. Dep.
1000 Ret. with dep.
Total 11,255

WHITE TEAM - Current Peds clinic (10 Providers)

10592 AD Dep.
1633 Ret. Dep.
1000 Ret. with Dep.
Total 13225

BLUE TEAM - Current OB Clinic (15 Providers + EFMP)

11500 AD Dep.
1633 Ret. Dep.
1000 Ret. with Dep.
Total 14133

Requirements for clinic:

- a. Office space for providers
- b. Administrative office space
- c. Office for Phone nurses/appt. clerks
- d. Waiting and Reception area
- e. Treatment areas (NST, Lab)
- f. Storage and soiled utility rooms
- g. Toilets

Since space is at a minimum, the most appropriate utilization of space is essential. Priority of space in this study was in providing space to providers to see patients in the most efficient manner. Administrative staff will share offices.

The standard of two exam rooms plus an office for each provider, with the space available, could not be accomplished. Each provider will have an office/exam room plus an exam room. According to staffing patterns, i.e., when 13 providers are assigned to an area on any given day, only 11 providers will be in the clinic. This is true 90% of the time. During the remaining time 9-13 providers will be present. Eleven exam rooms will be sufficient for 13 providers 90% of the time.

The discussion that follows will provide the requirements for each clinic and their placement in the clinic area. This is provided only as a sample.

A proposed alignment of the RED TEAM clinic:

The current Family Practice Clinic would house the RED TEAM of the Primary Care Complex. Ten providers would work out of this clinic.

Requirements:

- 10 Office/Exam rooms (Office of the Chief will not include exam area)
- 9 Exam rooms
- 1 Office Phone Nurses
- 1 Office appt. clerk
- 3 Treatment rooms
- 1 Soiled Utility
- 1 Reception area
- 1 Waiting area
- Triage area
- 1 Lounge

Tab A is a map of the area and possible location of requirements.

Offices:

All of the provider offices are intended to be office/exam rooms, with the exception of the Chief's. The offices identified for office /exam rooms are JCES1, 45, 37, 39, 31, 50, 27, 13, 5, and 17 Office of the Chief.

Exam room:

Exam rooms identified are 53, 49, 47, 43, 41, 35, 33, 25, 52, 15, 09, and 07. With the room available, 12 exam rooms were identified.

Lounge:

3CE21 will be the staff lounge for the clinic.

Housekeeping:

3CE49 is the room for housekeeping supplies.

Storage:

Room 3CE16 is a large room and it is where the current Family Practice Clinic stores its supplies.

Triage:

Room 3CE06 is the area currently used to triage patients in the FPC. A small area to the left of 3CE06 if used to augment the triage area. If the clinic feels that they need an additional room to triage, an exam room can be traded for a triage area.

Soiled Utility:

Room 3CE11 is the area currently used by the FPC for soiled items and will be sufficient for the Primary Care Clinic.

Treatment:

Three rooms were identified as treatment areas 3CE12, 14 and 19. The current FPC has 2 treatment areas and has expressed concerns about many times needing another one. NSTs are to be done in the screened off area in the hallway as they now are.

Reception:

3CE02 is the reception area for the current FPC and will be suitable for the Primary Care clinic.

Administrative areas:

Appointment clerks will be in 3CE55, NCOIC in 3CE22, Head Nurse in 3CE23 and phone nurses in 3CE02A.

Waiting area:

SPACE STUDY (ADDITIONAL RECOMMENDATIONS)

Due to minor changes in the original plan for the Primary Care Clinics, some space requirements also changed. Required changes are as follows:

- a. The patient representatives which are now in the old CCD area will need to move. As the plans for that new primary care clinic were completed, that space where the patient representatives are now located will be housing EFMB. The patient representatives require separate offices due to the privacy of the conversations with patients.
- b. Dr. Silkowski requested an additional office near the current Family Practice Clinic for the phone nurse. It is felt that the area where the phone nurse currently is, is too noisy and that the phone nurse would be more productive in a quiet office away from the reception area.
- c. An administrative officer will be appointed to the Primary Care Clinics, ~~and they~~ ^{who} will require office space.
- d. Quality Assurance nurse requires office space.

ACTIONS: Space is at a premium, so space for these requirements was not immediately available and needed to be found. To find the needed space required for the above 5 offices, Discharge Planning was looked at as a source of space and found to be acceptable. It has been a long-time goal for the Discharge Planners to be in or near the inpatient units they service, and this is an opportunity for this to occur.

- a. 4AB 76 was found to be an empty room that was an acceptable office for the Discharge Planner for Med/Surg. (Move one discharge planner from 3CF 36 to 4AB 76).
- b. 2AB is office space outside of the nursery that has been used for storage and taking baby pictures. The maternal child section was very agreeable to having the Discharge Planner that works maternal child have this office. The baby photos will be taken on post partum. (Move one discharge planner from 3CF 29 to 2AB 35).
- c. 3CF 35 is empty with the departure of a discharge planner, and there are no plans to rehire for that position.
- d. 3CF 33 is occupied by a Discharge Planner that also has an office on 3AB. (Move 3CF 33 Discharge Planner to one office on 3AB).

e. 3AB 37 has been used by the Pediatric Unit for a lounge. Move lounge to 3AB 35 inside of the Pediatric Unit. This will take away two beds from Pediatrics census. The average census of the ward is 7 patients. This move would leave their available capability at 18. This move would allow the Chief of Discharge Planning to be in the Social Work area that seems to be most appropriate.

(Move Chief of Discharge Planning from 3CF 37 to 3AB 37)

These above moves opens up 5 offices. The phone, LAN lines and exchange of locks are being coordinated.

RECOMMENDATION:

a. Move the Discharge Planners, as described above, to the recommended offices.

b. Move Patient representatives to 3CF 35 and 3CF 33
Move Administrative Resident to 3CF 37
Move Phone Nurse to 3CF 29 (Large room, could house 2 phone nurses)

Move QA nurse to 3CF 36

These moves would satisfy the requirements for space as stated.

c. Additional recommendations:

a. MAJ Kaiser move to 3AC 77 with SGT Fair. This will place him closer to the units that he will be supervising and accomplishing case management for. Utilization Management nurse working for CCD will occupy MAJ Kaiser's old office 3CF 38.

b. NCOIC of CSD move to 3AC 77.

c. The Red Cross move to 3AC 70 instead of to the Primary Clinic to be in the now OB Clinic. This will open up a room in the clinic for an additional exam room, etc. and be more convenient for the Red Cross. Red Cross was shown the room and found it to be acceptable. They spend very little time in their office and feel this office will be sufficient.

Recommend approval for these changes. All attempts were made to look closely at utilization of space at present and recommend changes that would add to the efficiency and productively to the organization. Offices that are located on 4AA are presently being moved, so 4AA can be prepared for the acceptance of 3AC. Goal is to have 4AA empty by 24 May 1993. Some Pediatric equipment that was stored on 4AA is now being stored in 2AC 81, which has not been used for a patient in at

least 6 months. Pediatrics did not want to turn the equipment in to the warehouse for fear that they would need it quickly for a patient.

PRIMARY CARE CLINICS SPACE ISSUES

PURPOSE: To examine space within the facility and determine which areas would be most appropriate for the Red, White, and Blue Primary Care Clinics.

DISCUSSION: The proposed composition of the health care providers is a combination of physicians, nurse practitioners, physician assistants and the support ancillary and administrative staff.

RED TEAM - Current Family Practice area (10 Providers)

8662 AD Dep.
1633 Ret. Dep.
1000 Ret. with dep.
Total 11,255

WHITE TEAM - Current Peds clinic (10 Providers)

10592 AD Dep.
1633 Ret. Dep.
1000 Ret. with Dep.
Total 13225

BLUE TEAM - Current OB Clinic (15 Providers + EFMP)

11500 AD Dep.
1633 Ret. Dep.
1000 Ret. with Dep.
Total 14133

Requirements for clinic:

- a. Office space for providers
- b. Administrative office space
- c. Office for Phone nurses/appt. clerks
- d. Waiting and Reception area
- e. Treatment areas (NST, Lab)
*Hand X-rays etc**
- f. Storage and soiled utility rooms
- g. Toilets

Since space is at a minimum, the most appropriate utilization of space is essential. Priority of space in this study was in providing space to providers to see patients in the most efficient manner. Administrative staff will share offices.

The standard of two exam rooms plus an office for each provider, with the space available, could not be accomplished. Each provider will have an office/exam room plus an exam room. According to staffing patterns, i.e., when 13 providers are assigned to an area on any given day, only 11 providers will be in the clinic. This is true 90% of the time. During the remaining time 9-13 providers will be present. Eleven exam rooms will be sufficient for 13 providers 90% of the time.

The discussion that follows will provide the requirements for each clinic and their placement in the clinic area. This is provided only as a sample.

A proposed alignment of the ^{WHITE} ~~RED~~ TEAM clinic:

The current Family Practice Clinic would house the RED TEAM of the Primary Care Complex. Ten providers would work out of this clinic.

Requirements:

- 10 Office/Exam rooms (Office of the Chief will not include exam area)
- 9 Exam rooms
- 1 Office Phone Nurses
- 1 Office appt. clerk
- 3 Treatment rooms
- 1 Soiled Utility
- 1 Reception area
- 1 Waiting area
- Triage area
- 1 Lounge

Tab A is a map of the area and possible location of requirements.

Offices:

All of the provider offices are intended to be office/exam rooms, with the exception of the Chief's. The offices identified for office /exam rooms are 3CE51, 45, 37, 39, 31, 50, 27, 13, 5, and 17 Office of the Chief.

Exam room:

Exam rooms identified are 53, 49, 47, 43, 41, 35, 33, 25, 52, 15, 09, and 07. With the room available, 12 exam rooms were identified.

Lounge:

3CE21 will be the staff lounge for the clinic.

Housekeeping:

3CE49 is the room for housekeeping supplies.

Storage:

Room 3CE16 is a large room and it is where the current Family Practice Clinic stores its supplies.

Triage:

Room 3CE06 is the area currently used to triage patients in the FPC. A small area to the left of 3CE06 if used to augment the triage area. If the clinic feels that they need an additional room to triage, an exam room can be traded for a triage area.

Soiled Utility:

Room 3CE11 is the area currently used by the FPC for soiled items and will be sufficient for the Primary Care Clinic.

Treatment:

Three rooms were identified as treatment areas 3CE12, 14 and 19. The current FPC has 2 treatment areas and has expressed concerns about many times needing another one. NSTs are to be done in the screened off area in the hallway as they now are.

Reception:

3CE02 is the reception area for the current FPC and will be suitable for the Primary Care clinic.

Administrative areas:

Appointment clerks will be in 3CE55, NCOIC in 3CE22, Head Nurse in 3CE23 and phone nurses in 3CE02A.

Waiting area:

3CE01 is a fairly large waiting area and will be sufficient space for patients waiting.

RED

A proposed alignment of the ~~WHITE~~ TEAM clinic:

The current Pediatric Clinic would house the WHITE TEAM of the Primary Care Complex. Ten providers would work out of this clinic.

Requirements:
Same as for RED TEAM.

Tab B is a map of the area and possible location of requirements.

Offices:

All of the offices are intended to be office/exam rooms. The only exception to this is the Office of the Chief. Rooms 2CR35, 35A, 29, 21, 12, 06, 13, 9, 01A, and 25 as Office of the Chief.

Exam rooms:

Rooms identified as exam rooms are 31, 27, 23, 32, 10, 08, 15, 11, and 03.

Lounge:

Consideration was given to not having a lounge in the area, but many potential problems demonstrated that the clinic needs a lounge. Room 2CR14 is the Pediatric Clinic's lounge now and is adequate.

Storage:

Room 2CR07 is identified as a storage room. If adequate supplies could be placed in the treatment rooms, than this room could be used as an exam room.

Triage? Are sinks required for triage? NO?

The area 2CR39 could be easily divided up into 3 triage areas. This could be done by the use of partitions or by a minor construction project.

Soiled Utility:

Room 2CR19 is the clinic's present soiled utility and will be adequate.

Treatment rooms:

Three rooms are identified-17, 01 and 38. Three areas for treatment would be adequate for a clinic with 10 providers. NSTs would be done in the screened off area identified on the map as they are now done in FPC.

Waiting area:

Pediatric clinic has a large waiting room and would be adequate waiting area for this clinic.

Administrative areas:

2CR28 is identified for secretary and phone nurse(s). 2CR30 would be an office for the head nurse and wardmaster. The appointment clerks, because of space constraints, would be located in the old CCD in room 2CU04.

Reception area:

2CR04 is the current reception area for Pediatric Clinic and would be adequate for 3 medical clerks.

A proposed alignment of the BLUE TEAM clinic:
This clinic would have 15 providers plus EFMP.

The current OB clinic would house the BLUE TEAM of the Primary Care Complex. It is the largest of the clinics.

Requirements:

- 15 Offices/Exam Rooms
- 13 exam rooms
- 1 appointment clerks
- 3 treatment areas
- 1 soiled utility
- 1 reception area
- 1 waiting area
- Triage area
- Lounge
- Offices for EFMP
- 1 Office for Red Cross

Tab C is a map of the area and possible location of requirements.

Offices:

The rooms identified as offices are 2CR17, 23, 41, 31, 29, 27, 22, 49, 53, 48, 20, 14, 21, 15, and 27 Office of the Chief.

Exam rooms:

Rooms identified as exam rooms are 2CX19, 20, 21, 25, 2CT39, 33, 25, 51, 50, 52, 18, 16, 19, and 17. 14 exam areas were identified.

Lounge:

2CT37 is the lounge for the current OB clinic and will be adequate for the BLUE TEAM clinic.

Housekeeping:

2CT45 identified for housekeeping.

Storage:

2CT34 is a large room and will be sufficient for storage.

Triage:

2CT07 and 2CT09 are set aside for triage areas. Each room could be arranged to have 2 triage areas in them, using partitions.

Soiled Utility:

2CT46 is the soiled utility for the current OB clinic and will be sufficient for the primary care clinic.

Treatment:

Three areas plus a NST room have been identified. Room 2CT35, 2CT12, and 2CT47 are noted on the map as treatment areas. Three should be sufficient for this clinic. Note NST room on map.

Reception:

2CT07 is the current reception area for OB clinic and will be sufficient for primary care clinic.

Administrative areas:

2CX29 is identified as office of the head nurse and wardmaster. Phone nurses will be in 2CT43. Appointment clerks will be located in room 2CU06.

Waiting area:

This clinic has a large waiting area and should be sufficient for the primary care clinic.

EFMP: Requires 3 offices. Screening nurse has moved to the third floor, or plans to, which was the fourth office. These offices would be in 2CU08,07 and 05 in the old CCD area.

Red Cross:

The Red Cross must be relocated because of the move of 3AC to 4AA. Their office would be in 2CT23.

Conference room: Recommend that this room be a resource for BACH. This room should be used on a scheduled basis to be most useful.

This configuration of the Primary Care Complex would necessitate the movement of OB Clinic. Recommend moving OB clinic to 3AC.

A proposed alignment of 3AC to the OB clinic:

Requirements:

12 offices (11.5 practitioners and intermittent consultant)

9 exam rooms

1 lounge

1 housekeeping

1 small lab

2 large rooms and one small room for the Dept of Nursing

1 treatment room

1 NST room

Reception area

Administrative offices (including secretary, patient educator, phone nurse)

2 Triage areas

Storage

Tab D demonstrates the possible location of these requirements. This is only an example. The space could be divided in many ways to best fit the needs of the clinic. 11.5 providers will fit into the clinic with the necessary support staff.

Offices:

All of the provider offices are intended to be office/exam rooms. The only exception to this is the office of the Chief. Offices identified are rooms 99, 97, 91, 89, 85, 83, 79, 73, 69, 63, 61, and 88 Office of the Chief. Intermittent consultant and the .5 practitioner would share an office.

Exam rooms:

The majority of the rooms on 3AC have sinks in them, and those are the rooms identified as exam rooms. If other than those rooms with sinks are identified as exam rooms, then sinks will need to be added to the rooms. Rooms 95, 93, 87, 81, 71, 67, 65, 59, and 57 have been identified as exam rooms.

Lounge:

The pantry, room 56, has been identified as the lounge. It is not a large room but large enough for a table that would accommodate 3-4 persons on break. It has a refrigerator and microwave.

Housekeeping:

Room 90 is the room for the storage of the housekeeping items.

Storage:

Room 62 is a very large room, which would be the area for central supply.

Triage:

Rooms 51 and 53 were identified as Triage rooms. Each room could easily accommodate 2 triage areas if necessary.

Lab:

Room 58 (Soiled Utility) has a large counter, which could be used as a small lab.

Treatment/NST:

Room 72 is a treatment room presently and has all of the needed O2, suction, etc,. Room 55 is identified as a NST room. Could do 2-3 NSTs at any one time.

Reception area:

There are two options for reception areas in this area or the clinic could have two. Part of the waiting area, which is very large, could be structured to be a reception area, and also in the middle of the unit there is a reception area.

Administrative areas:

Appointment clerks and secretary will be in room 92, phone nurse(s) in room 94, and the patient educator in room 54. Head Nurse and Wardmaster share an office in room 68.

Waiting area:

3AC has a very large waiting area that would accommodate the number of patients waiting for their OB appointments.

Areas that will be other than assets of the OB Clinic:

Room 75, and 76 will be assets of the Dept of Nursing and 77 will be a training room that can be used by the facility as well as OB clinic for training. Room 73 will be SGT. Duffle's office.

Allergy/Derm (Tab E) was looked at to possibly flip/flop with Social Work Service. Allergy/Derm is too large to fit into Social Work Service, so this would not work.

Recommendations are as follows:

- a. All offices/exam rooms be divided by a partition so the flow of patients can be as efficient as possible (where space permits).
- b. Attempt to find room to collocate all appointment clerks so they can be taken out of the clinic areas to provide more space to the clinics.
- c. This is a major change for this institution, and to make it as smooth as possible, early involvement of all personnel will facilitate the change.
- d. Get IMD involved early to identify any cabling needs on the units for LAN interface, etc.
- e. Get PAO early involvement to education staff and patients.
- f. Identify phone lines and required locks early so work orders can be placed.
- g. Address safety issues such as back classes ahead of move.
- h. Identify equipment needs so they may be ordered soon.
- i. Create Perk chart with milestones for each move.

In conclusion, the recommendation is to move:

3AC to 4AA (Tab F) Area's are of same size.

OB clinic to 3AC

Leave Psych/Social Work where they are now located.

The three Primary Care Clinics would be the current Family Practice Clinic, the OB clinic and the Pediatric Clinic. The clinics are arranged slightly different because of space issues.

Dated: 27 May 1993

PRIMARY CARE CLINICS

**RED, WHITE and BLUE TEAMS
RELOCATION OF CLINICS**

TEAM	NEW LOCATION	CURRENT STATUS	CURRENT ROOM #	AREA	PROPOSED ROOM #	STATUS
WHITE	FP area	1 AQ term	3CE02	Reception Area	3CE02	OK
		2 AQ term	3CE49	Appointment Clerks	3CE49	OK
		1 AQ term/prt	3CE02A	THCAN	?	
		1 LAB/LAN PC	3CE02A	Secretary	3CE02A	OK
		1 LAB prt	3CE02	Reception Area	3CE02	OK
				NCOIC/HN	3CE23	LAN line
RED	PED area	2 AQ term	2CR04	Reception Area	2CR04	OK
		2 AQ term/prt	2CR09	Appointment Clerks	2CR38	new lines
		1 AQ term/prt	2CR11	THCAN	2CR39	new lines
		1 AQ drop	2CR02			
		1 AQ drop	2CR05			
		1 LAN/LAB	2CR05	Secretary	2CR05	OK
		1 LAB prt	2CR06	Head Nurse area	2CR04	move line
				NCOIC/HN	2CR03	LAN line
BLUE	OB area			OIC	2CR25	LAN line
		2 AQ term	2CT07	Reception Area	2CT07,09	OK
		2 AQ term	2CX27	Appointment Clerks	2CT19,21	new lines
		1 AQ term/prt	2CX29	THCAN	2CT43	new lines
		1 LAB/LAN	2CU04	Secretary		
		1 LAB prt	2CT07	Reception Area	2CT07	OK
EFMP	OB area			Office	2CU08	LAN ?
				Computer Room	2CX27	LAB/LAN
EFMP	OB area	1 LAN coax	2CR21	EFMP	2CU06	
		1 LAN coax	2CR25	EFMP	2CU04	
PT REP	PSY area	1 LAN coax	2CU01			new lines
		1 LAN coax	2CU03			new lines
ADM RES	PSY area	1 LAN drop				new lines

***** CONTACTS *****

Dr. Pete Silkowski

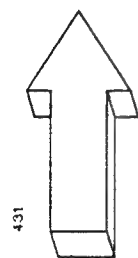
SFC Boyles (Blue Team) #8147 Beeper 953

SFC Reynolds (White Team) #5321

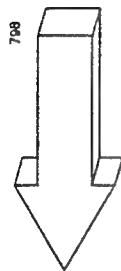
SFC Blanton (Red Team) #8141

HOSP

30 Commercial
Telephone Lines



BACH Switch



10 Post Numbers

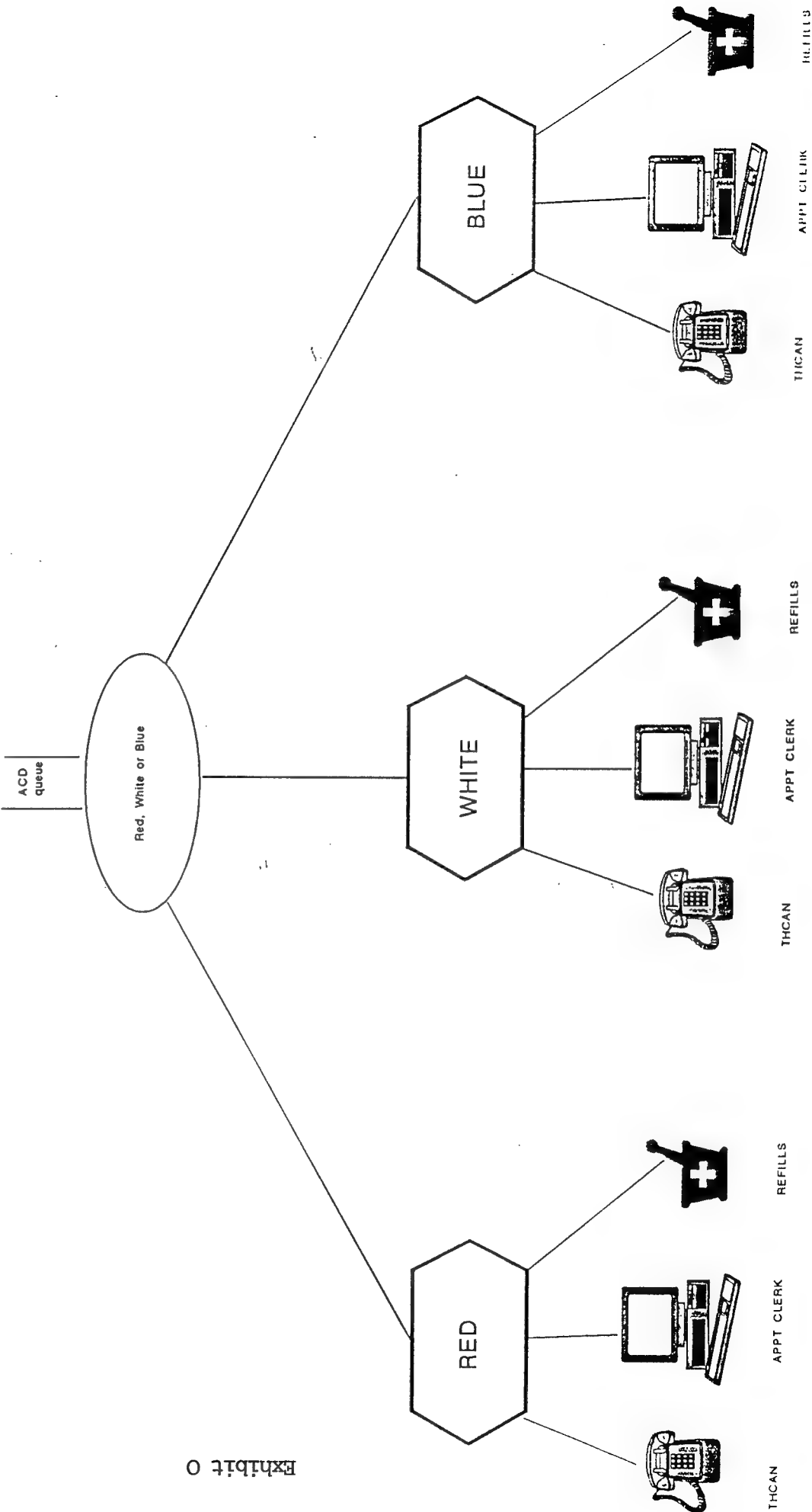
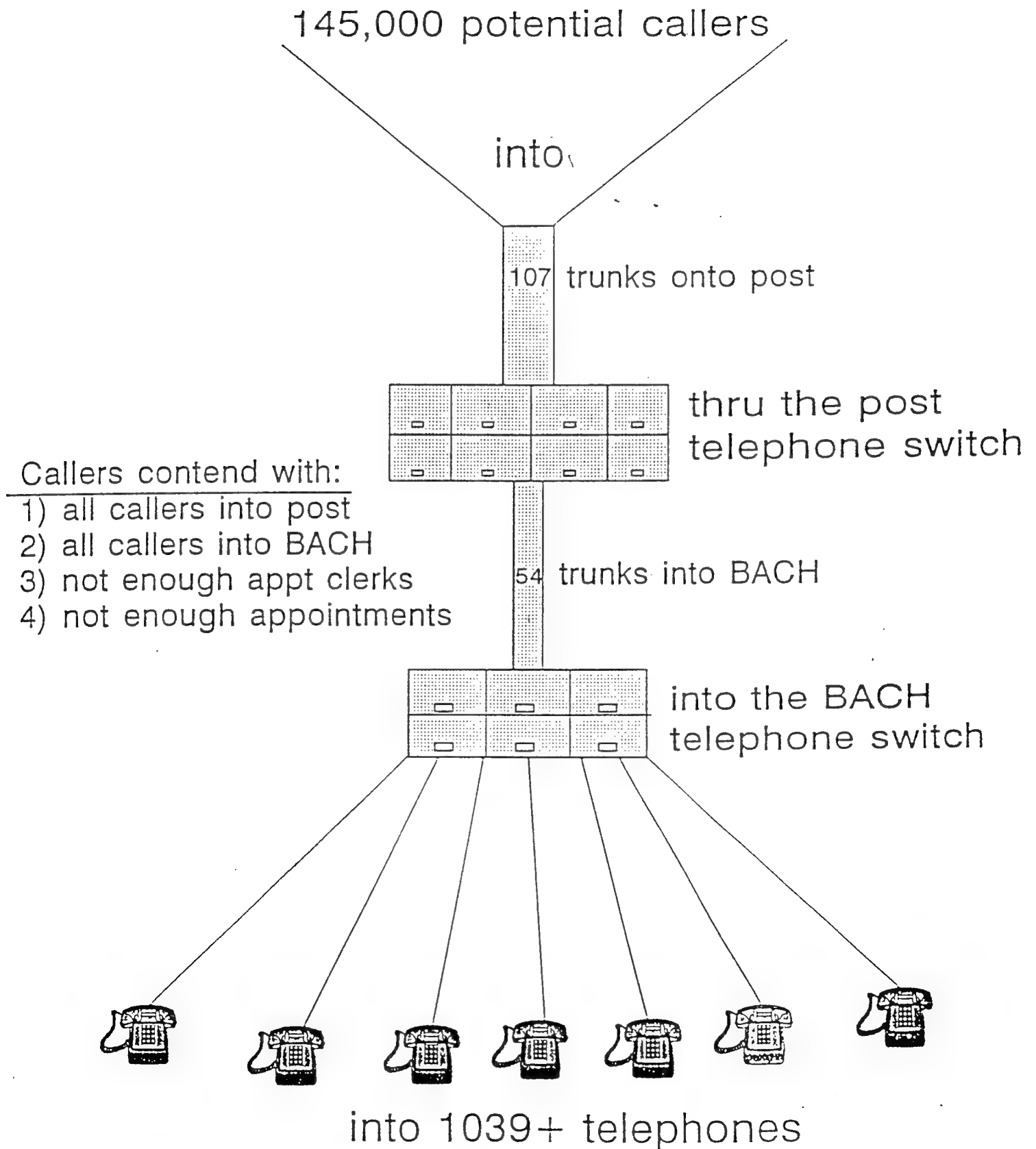


Exhibit O

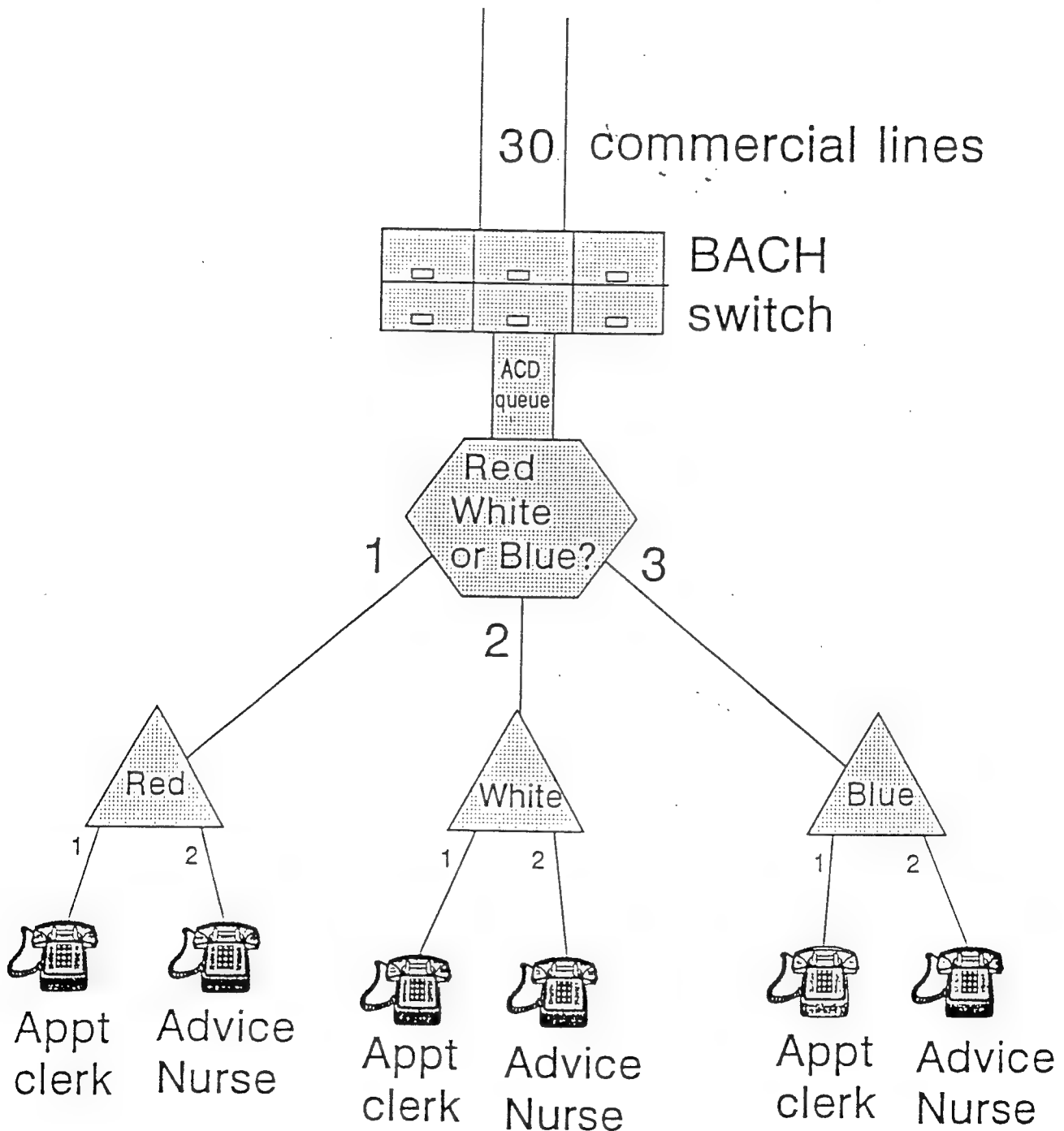
The Problem:

a communications bottleneck



A Solution to the problem:

Lease commercial lines and use call queuing and automatic call distribution



The Cost of the Solution

- Commercial Lines:

\$61.25 per line per month

x 30 lines

x 12 months

\$22,050 per year

-\$7,030 currently spent on commercial lines

\$15,020 cost increase

- Voice Processor Ports

Option

1 - 4 ports -- cost: \$25,818

2 - 8 ports -- cost: \$36,766

3 - 12 ports -- cost: \$47,714

- Recommend option 2 - cost: \$36,766

- Total cost: \$51,786

NOTE: - These proposals are NOT dependent
upon Primary Care Reorganization



DEPARTMENT OF THE ARMY
HEADQUARTERS MEDICAL DEPARTMENT ACTIVITY
FORT CAMPBELL, KENTUCKY 42223-1498



REPLY TO
ATTENTION OF.

HSXD-PC-FPC

Exhibit P

15 June 1993

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Primary Care Initiative Research Questionnaire Project
at Blanchfield Army Community Hospital

1. Blanchfield Army Community Hospital is currently undergoing a reorganization of its Primary Care. This reorganization will provide our patients with their own clinic for Primary Care. This initiative is designed to improve patient care and access in a more efficient and organized manner.
2. A independent research project concerning the effects and results of this reorganization will be instituted to determine how our patients feel before and after the system takes effect. This project will be confidential and will focus on the following groups: Hospital Providers, Hospital Commanders, Active Duty Dependents, Active Duty Soldiers, Force Commanders and Retirees. This important study will require your participation now and later after the new system has been in effect for 3 months. This study will be presented to our Medical Commander and a National Medical Convention in Mar 94.
3. Please take time to answer the questionnaire now and provide a Point of Contact for a follow-up questionnaire in Jan 94. We appreciate your time and help in this very important manner. Questions could be addressed to Doctor Barthel, #8310. Return questionnaires to Family Practice Service care of Doctor Barthel.

HERMAN J. BARTHEL
MAJ, MC
Chief, Family Practice Service

DISTRIBUTION:

Hospital Commanders
Hospital Providers
Active Duty Dependents
Active Duty Soldiers
Force Commanders
Retirees

FORCE COMMANDER QUESTIONNAIRE

SCALE 5 = Outstanding/Strongly Agree
 4 = Very Good
 3 = Good
 2 = Fair
 1 = Poor/Strongly Disagree

01	Rate the overall quality of health care at Blanchfield Army Community Hospital (BACH)?	5 4 3 2 1
02	How do you rate our services in comparison to other military hospitals?	5 4 3 2 1
03	How well do you like the concept of having your own Primary Care Clinic?	5 4 3 2 1
04	How is your access to getting an appointment in our hospital for your dependents?	5 4 3 2 1
05	How do you rate your dependents ability to get seen in their clinics on the same day?	5 4 3 2 1
06	Can your dependents identify their Primary Care Clinic?	5 4 3 2 1
07	How is the soldiers access to getting an appointment or seen in their TMC?	5 4 3 2 1
08	How do you rate the soldiers ability to get seen timely in their clinics on the same day?	5 4 3 2 1
09	How do you rate retirees access to medical care at BACH?	5 4 3 2 1
10	How do you rate retirees satisfaction with medical care at BACH?	5 4 3 2 1
11	BACH's ability to provide for medical care of dependents during deployments of the 101st?	5 4 3 2 1
12	Overall quality of the health care providers at BACH?	5 4 3 2 1
13	Overall quality of the health care providers at the TMC's?	5 4 3 2 1

FORCE COMMANDER QUESTIONNAIRE (cont)

- | | | |
|----|--|-----------|
| 14 | How well do you perceive Military Physicians as Military Officers? | 5 4 3 2 1 |
| 15 | How well do you compare military health care providers with civilian? | 5 4 3 2 1 |
| 16 | How do you perceive the workload of the BACH's health care providers? | 5 4 3 2 1 |
| 17 | How do you perceive the workload of the TMC's health care providers? | 5 4 3 2 1 |
| 18 | How do you perceive the concern and caring attitude of the health care providers to the soldiers and their dependents? | 5 4 3 2 1 |

COMMENTS:

Point of Contact:

NAME:

ADDRESS:

PHONE:

ACTIVE DUTY SOLDIER QUESTIONNAIRE

SCALE 5 = Outstanding/Strongly Agree
 4 = Very Good
 3 = Good
 2 = Fair
 1 = Poor/Strongly Disagree

- | | | |
|----|---|-----------|
| 01 | Rate the overall quality of health care at Blanchfield Army Community Hospital (BACH)? | 5 4 3 2 1 |
| 02 | How do you rate our services in comparison to other military hospitals? | 5 4 3 2 1 |
| 03 | How well do you like the concept of having your own Primary Care Clinic? | 5 4 3 2 1 |
| 04 | How is your access to getting an appointment in our hospital for your dependents? | 5 4 3 2 1 |
| 05 | How do you rate your dependents ability to get seen in their clinics on the same day? | 5 4 3 2 1 |
| 06 | Can your dependents identify their Primary Care Clinic? | 5 4 3 2 1 |
| 07 | How is the soldiers access to getting an appointment or seen in their TMC? | 5 4 3 2 1 |
| 08 | How do you rate the soldiers ability to get seen timely in their clinics on the same day? | 5 4 3 2 1 |
| 09 | How do you rate retirees access to medical care at BACH? | 5 4 3 2 1 |
| 10 | How do you rate retirees satisfaction with medical care at BACH? | 5 4 3 2 1 |
| 11 | BACH's ability to provide for medical care of dependents during deployments of the 101st? | 5 4 3 2 1 |
| 12 | Overall quality of the health care providers at BACH? | 5 4 3 2 1 |
| 13 | Overall quality of the health care providers at the TMC's? | 5 4 3 2 1 |

- | | | |
|----|--|-----------|
| 14 | How well do you perceive Military Physicians as Military Officers? | 5 4 3 2 1 |
| 15 | How well do you compare military health care providers with civilian? | 5 4 3 2 1 |
| 16 | How do you perceive the workload of the BACH's health care providers? | 5 4 3 2 1 |
| 17 | How do you perceive the workload of the TMC's health care providers? | 5 4 3 2 1 |
| 18 | How do you perceive the concern and caring attitude of the health care providers to the soldiers and their dependents? | 5 4 3 2 1 |

COMMENTS:

Point of Contact:

NAME:

ADDRESS:

PHONE:

RETIREE QUESTIONNAIRE

SCALE 5 = Outstanding/Strongly Agree
 4 = Very Good
 3 = Good
 2 = Fair
 1 = Poor/Strongly Disagree

01	Rate the overall quality of health care at Blanchfield Army Community Hospital (BACH)?	5 4 3 2 1
02	How do you rate our services in comparison to other military hospitals?	5 4 3 2 1
03	How well do you like the concept of having your own Primary Care Clinic?	5 4 3 2 1
04	How is your access to getting an appointment in our hospital?	5 4 3 2 1
05	Do you like phone consults; the physician calling you at home in response to your phone messages/abnormal test results?	5 4 3 2 1
06	Do you find the triage phone nurse helpful and courteous?	5 4 3 2 1
07	How do you rate your ability to get seen in your clinic on the same day?	5 4 3 2 1
08	Can you identify your Primary Care Clinic?	5 4 3 2 1
09	Quality of the phone system at the hospital?	5 4 3 2 1
10	How hard do you feel your military health care providers work?	5 4 3 2 1
11	How well did we respond to any problem you had?	5 4 3 2 1
12	Please rate the Pharmacy Services?	5 4 3 2 1
13	Please rate the Laboratory Services?	5 4 3 2 1
14	Please rate the X-Ray Services?	5 4 3 2 1

- | | | |
|----|---|-----------|
| 15 | How long was your waiting time to see the doctor once you checked in? | 5 4 3 2 1 |
| 16 | Were you treated courteously by the nursing personnel? | 5 4 3 2 1 |
| 17 | Were you treated courteously by the Physician? | 5 4 3 2 1 |
| 18 | Overall quality of health care providers at BACH? | 5 4 3 2 1 |
| 19 | How do you rate health care providers at BACH in comparison with civilian health care providers? | 5 4 3 2 1 |
| 20 | How do you perceive the concern and caring attitude of the health care providers to your medical needs? | 5 4 3 2 1 |

COMMENTS:

Point of Contact:

NAME:

ADDRESS:

PHONE:

ACTIVE DUTY DEPENDENT QUESTIONNAIRE

SCALE 5 = Outstanding/Strongly Agree
 4 = Very Good
 3 = Good
 2 = Fair
 1 = Poor/Strongly Disagree

01	Rate the overall quality of health care at Blanchfield Army Community Hospital (BACH)?	5 4 3 2 1
02	How do you rate our services in comparison to other military hospitals?	5 4 3 2 1
03	How well do you like the concept of having your own Primary Care Clinic?	5 4 3 2 1
04	How is your access to getting an appointment in our hospital?	5 4 3 2 1
05	Do you like phone consults; the physician calling you at home in response to your phone messages/abnormal test results?	5 4 3 2 1
06	Do you find the triage phone nurse helpful and courteous?	5 4 3 2 1
07	How do you rate your ability to get seen in your clinic on the same day?	5 4 3 2 1
08	Can you identify your Primary Care Clinic?	5 4 3 2 1
09	Quality of the phone system at the hospital?	5 4 3 2 1
10	How hard do you feel your military health care providers work?	5 4 3 2 1
11	How well did we respond to any problem you had?	5 4 3 2 1
12	Please rate the Pharmacy Services?	5 4 3 2 1
13	Please rate the Laboratory Services?	5 4 3 2 1
14	Please rate the X-Ray Services?	5 4 3 2 1

- | | | |
|----|---|-----------|
| 15 | How long was your waiting time to see the doctor once you checked in? | 5 4 3 2 1 |
| 16 | Were you treated courteously by the nursing personnel? | 5 4 3 2 1 |
| 17 | Were you treated courteously by the Physician? | 5 4 3 2 1 |
| 18 | Overall quality of health care providers at BACH? | 5 4 3 2 1 |
| 19 | How do you rate health care providers at BACH in comparison with civilian health care providers? | 5 4 3 2 1 |
| 20 | How do you perceive the concern and caring attitude of the health care providers to your medical needs? | 5 4 3 2 1 |

COMMENTS:

Point of Contact:

NAME:

ADDRESS:

PHONE:

PROVIDERS QUESTIONNAIRE

SCALE 5 = Outstanding/Strongly Agree
 4 = Very Good
 3 = Good
 2 = Fair
 1 = Poor/Strongly Disagree

01	Overall satisfaction of your practice at Blanchfield Army Community Hospital (BACH)?	5	4	3	2	1
02	Your ability to perform your medically trained skills?	5	4	3	2	1
03	Your workload at BACH in comparison to other practices you have experienced.	5	4	3	2	1
04	Ability to spend needed time with difficult patients?	5	4	3	2	1
05	Ability to schedule procedures in your clinic?	5	4	3	2	1
06	Do you have an adequate amount of ancillary support?	5	4	3	2	1
07	Do you find the provider to patient ratio to be excessive at BACH?	5	4	3	2	1
08	How important is telephone medicine to your practice at BACH?	5	4	3	2	1
09	What is your perceived perception of your patients satisfaction with your clinic's care?	5	4	3	2	1
10	What is your perceived perception of your patients ability to get access to your clinic?	5	4	3	2	1
11	Are you satisfied with the call schedule?	5	4	3	2	1
12	Are you satisfied with your inpatient care responsibilities?	5	4	3	2	1
13	Do you have enough off-duty time available for your family?	5	4	3	2	1
14	Clinic colleagues professional interaction?	5	4	3	2	1
15	Intradepartmental colleagues professional interaction?	5	4	3	2	1

- | | | |
|----|---|-----------|
| 16 | Amount of administrative time? | 5 4 3 2 1 |
| 17 | Commands recognition of your clinics problems? | 5 4 3 2 1 |
| 18 | Commands support of your clinics problems? | 5 4 3 2 1 |
| 19 | Future of your specialty in the Army? | 5 4 3 2 1 |
| 20 | Will you stay in the Army? | 5 4 3 2 1 |
| 21 | Has your experience in the Army at BACH influence your decision to stay in the Army? | 5 4 3 2 1 |
| 22 | Do patients use the Emergency Room appropriately? | 5 4 3 2 1 |
| 23 | Quality of care delivered in your clinic? | 5 4 3 2 1 |
| 24 | BACH's reputation in the US Army Medical System? | 5 4 3 2 1 |
| 25 | Overall satisfaction of retirees care at BACH? | 5 4 3 2 1 |
| 26 | Patients ability in the catchment area to identify their Primary Care Clinic? | 5 4 3 2 1 |
| 27 | Quality of phone system at BACH? | 5 4 3 2 1 |
| 28 | Are the soldiers of the 101st satisfied that their dependent will be adequately cared for in time of their deployments? | 5 4 3 2 1 |

COMMENTS:

Point of Contact:

NAME:

ADDRESS:

PHONE:

HOSPITAL COMMANDERS QUESTIONNAIRE

CO, DCCS, DCA, C,DON, C,DOS, C,DPCCM,
C,PCC #1, C,PCC #2, C,PCC #3

SCALE 5 = Outstanding/Strongly Agree
4 = Very Good
3 = Good
2 = Fair
1 = Poor/Strongly Disagree

01	Overall satisfaction of your providers practice at Blanchfield Army Community Hospital (BACH)?	5	4	3	2	1
02	The ability of your providers to perform their medically trained skills?	5	4	3	2	1
03	Your providers workload in comparison to other practices in the Army?	5	4	3	2	1
04	Your providers ability to spend needed time with difficult patients?	5	4	3	2	1
05	Your providers ability to schedule procedures in their Clinics?	5	4	3	2	1
06	Does your staff have adequate ancillary support?	5	4	3	2	1
07	Do you find the provider to patient ratio to be excessive at BACH?	5	4	3	2	1
08	How important is Telephone Medicine to the medical practice at BACH?	5	4	3	2	1
09	What is your perceived perception of the patients satisfaction with BACH care?	5	4	3	2	1
10	What is your perceived perception of the patients ability to get access to care at BACH?	5	4	3	2	1
11	Are your providers satisfied with the Call Schedule?	5	4	3	2	1
12	Are your providers satisfied with their inpatient care responsibilities?	5	4	3	2	1

HOSPITAL COMMANDERS QUESTIONNAIRE (cont)

- | | | |
|----|--|-----------|
| 13 | Does your staff have enough off-duty time available for their families? | 5 4 3 2 1 |
| 14 | Providers professional interactions in their respective clinics? | 5 4 3 2 1 |
| 15 | Providers professional interactions intra-departmentally? | 5 4 3 2 1 |
| 16 | Providers amount of administrative time? | 5 4 3 2 1 |
| 17 | Your recognition of BACH's individual clinic problems? | 5 4 3 2 1 |
| 18 | Your Support of BACH's individual clinic problems? | 5 4 3 2 1 |
| 19 | Future of your providers specialties in the Army? | 5 4 3 2 1 |
| 20 | Will your providers stay in the Army? | 5 4 3 2 1 |
| 21 | Has your providers experience in the Army at BACH influence their decision to stay in the Army? | 5 4 3 2 1 |
| 22 | Do BACH's patients use the Emergency Room appropriately? | 5 4 3 2 1 |
| 23 | Quality of care delivered at BACH? | 5 4 3 2 1 |
| 24 | BACH's reputation in the US Army Medical System? | 5 4 3 2 1 |
| 25 | Overall satisfaction of retirees care at BACH? | 5 4 3 2 1 |
| 26 | Patients ability in the catchment area to identify their Primary Care Clinic? | 5 4 3 2 1 |
| 27 | Quality of phone system at BACH? | 5 4 3 2 1 |
| 28 | Are the soldiers of the 101st satisfied that their dependents will be adequately cared for in time of their deployments? | 5 4 3 2 1 |

COMMENTS:

HSXD-PC (40)

2 November 1993

MEMORANDUM FOR MEDDAC, DENTAC, MEDICAL HOLD COMPANY STAFF

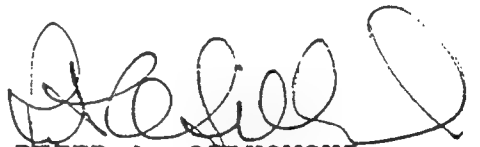
SUBJECT: Sick Call and Dependent Care in the Primary Care Clinics (PCC's)

1. On 15 November 1993, the Family Practice Clinic, Pediatric Clinic and part of the OB/GYN Clinic will combine forming three Primary Care Clinic (PCC's). The Family Practice Clinic and the Pediatric Clinic will no longer exist; the Family Practice Clinic will become the White Clinic, the Pediatric Clinic will become the Red Clinic, and the "old" OB/GYN Clinic will become the Blue Clinic.

2. MEDDAC, DENTAC, and Medical Hold Company soldiers and their dependents will receive their Primary Care Services (sick call and routine and same day appointments) in either the Red, White, or Blue Primary Care Clinics based on the last # of the Active Duty Sponsor's SSN as follows.

0 - 3 Red Clinic
4 - 6 White Clinic
7 - 9 Blue Clinic

4. Sick call hours in each Primary Care Clinic are 0730-0830 Monday thru Friday. Supervisors are encouraged to allow their soldiers to go on sick call before 0800 each day. Soldiers needing routine services like follow-up of a chronic problem should make a routine appointment in their respective clinic. Prescription renewals can be phoned to the clinic and will be ready for pick up in 72 hours.



PETER A. SILKOWSKI

MAJ, MC

Chief, Department of Primary Care
and Community Medicine

Blanchfield reorganizes primary care clinics

YBETINA TILSON
of The Leaf-Chronicle Staff

Delivering primary medical care more efficiently and providing patients with better access to this are the goals behind an upcoming reorganization of three clinics at Florence A. Blanchfield Army Community Hospital.

The Family Practice Clinic, the Pediatric Clinic and part of the Obstetrics Gynecology Clinic will be restructured to form three primary care clinics titled the Red, White and Blue clinics.

Each clinic will be a mirror image of the other two," explained Maj. Peter Silkowski, chief of Blanchfield's Primary Care Department.

The reorganized clinics are scheduled to open on Nov. 15.

"We're trying to increase proficiency by how we are structured and organized," said Col. George Brown, Blanchfield commander.

"We're trying to increase proficiency by how we are structured and organized. All other services are unaffected by these changes."

—Col. George Brown, Blanchfield commander

"All other services are unaffected by these changes," he said.

Active duty soldiers will continue to use the six Troop Medical Clinics on post, while the new clinics will be reserved for soldiers' families.

Family members will be assigned to either the Red, White or Blue clinic, depending on their sponsor's military unit, or in some cases, the last number of the sponsor's social security number.

Fort Campbell has at least 50 separate units, and information about clinic assignments can be obtained from the unit first sergeant.

Some of the larger units and their assigned primary clinics include 1st Brigade, red; 2nd Brigade, blue; 3rd Brigade, white; 101st Airborne Division Artillery, blue; Aviation Brigade, white; Division Support Command, blue; and most of the 101st Support Group (Corps), red.

A variety of common medical services will be available at the Red, White and Blue clinics, including Pap Smears, blood pressure checks, immunizations, "well child" care and the treatment of colds and other acute minor illnesses.

About 800 retiree families enrolled in the former Family Practice

See BACH page A2, column 3

Upcoming changes at Florence A. Blanchfield Community Hospital

Some clinics will be reorganized, others relocated. The following changes will occur in November:

- Nov. 1 — The current OB-GYN Clinic will move to Ward 3AC. Pediatric Clinic will become the Red Clinic, and the "old" OB/GYN Clinic will become the Blue Clinic.
- Nov. 15 — The Routine OB Clinic will become part of the Red, White and Blue clinics and routine OB patients will receive their prenatal care in their assigned primary clinic.
- Nov. 15 — The OB/GYN Walk-In Clinic will close and patients will be seen on a same day appointment basis in their assigned primary clinic.
- The Exceptional Family Member Program and special pediatrics will move to the Blue Clinic. Their phone numbers and clinic procedures are unchanged.
- Telephone numbers for the Red, White and Blue clinics: 431-HOSP (4677) or 798-HOSP (4677).
- The Outpatient Clinic will continue to provide primary care for CHAMPUS eligible retirees and retiree dependents, age 14-65.
- Medicare eligible retirees will be seen by a non-CHAMPUS provider when available in the Outpatient Clinic. If appointments are not available in the Outpatient Clinic, a Health Care Finder will assist retirees and retiree dependents. The Health Care Finder Number is (502) 798-8280.

Note: The changes above do not allow the scheduling of routine and follow up appointments in the Primary Care Clinics before Nov. 15. Patients wanting these should call their unit after 3 p.m. starting on Nov. 15. Same day appointments will be available each day for patients in each same day medical care. The Red, White and Blue clinics will not have a walk-in service. A patients must have appointments and should call to obtain one of the same day appointments.

BEST AVAILABLE COPY

BACH

Continued from page A1

tice Clinic will be assigned to the primary care clinic where their current family doctors will be working. Clinic assignment information in these cases will be available in the Family Practice Clinic until Nov. 10 and in each primary clinic after Nov. 15.

"Because we will not have a Pediatric Clinic, we will need to have a place for the children of retirees to get their care," Silkowski said. Children 13 or younger will be treated in the primary clinics.

Children whose sponsor's social security number ends in 0-3 will be assigned to the Red Clinic; 4-6 to the White Clinic; and 7-9 to the Blue Clinic.

Retirees and their children 14 or older will receive their primary care in the Outpatient Clinic.

Other changes also are taking place in November at Blanchfield.

Thirty new commercial telephone lines will be installed and hooked up to an automated call distribution system that will direct

patients' calls more quickly. Patients with touch-tone telephones can call the primary clinics for appointments, messages, prescription refills, lab results or for the advice nurse.

Officials said they hope the new system will simplify the appointment process for patients. "It will be a lot more efficient and less frustrating," Brown said.

All three primary clinics can be reached by calling the same telephone number — 798-HOSP (4677) and 431-HOSP (4677).

Blanchfield has about 70,000 potential patients who live in a 40-mile radius of Fort Campbell. "We're trying to educate our patients about the changes that will occur on Nov. 15," Brown said.

Members of the hospital staff are excited about the changes, and many have started showing their enthusiasm — and a healthy competitive spirit. "Some of the staff have begun sporting red, white or blue T-shirts," Brown said.

COMPARISON OF PATIENT ENCOUNTERS PRE AND POST PRIMARY CARE REORGANIZATION

CLINIC	COMPL	PHONE	POLICY	ASST INFO	ATTITUDE	QUAL CARE	APPT
<u>15 OCT - 10 NOV</u>							
PEDS	0	2	2	13	0	0	4
FPC	1	0	0	8	0	0	0
TOTALS	1	2	2	21	0	0	4
<u>15 NOV - 15 DEC</u>							
RED	1	30	5	14	0	1	0
WHITE	1	23	5	10	3	0	0
BLUE	1	57	3	16	0	2	1
TOTAL	3	110	13	40	3	3	1

COMPARISON OF PATIENT ENCOUNTERS EMERGENCY CENTER 15 OCT - 15 DEC 1993

ENCOUNTER	CLINIC	15 OCT	15 NOV
		10 NOV	15 DEC
COMPLIMENTS	EC	1	
PHONE			
APPT			
POLICIES		1	1
ASST/INFO			
ATTITUDE			5
QUALITY CARE			5

COMPARISON OF PATIENT ENCOUNTERS PRE AND POST PRIMARY CARE REORGANIZATION

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CLINIC	COMPL	PHONE	POLICY	ASST INFO	ATTITUDE	QUAL CARE	APPT
<u>15 OCT - 10 NOV</u>							
PEDS	0	2	2	13	0	0	4
FPC	1	0	0	8	0	0	0
TOTALS	1	2	2	21	0	0	4
<u>15 NOV - 15 DEC</u>							
RED	1	30	5	14	0	1	0
WHITE	1	23	5	10	3	0	0
BLUE	1	57	3	16	0	2	1
TOTAL	3	110	13	40	3	3	1

COMPARISON OF PATIENT ENCOUNTERS

15 OCT 1993 - 15 FEB 1994

RED, WHITE, BLUE, EC

ENCOUNTER	15 OCT* 10 NOV	15 NOV 15 DEC	16 DEC 15 JAN	16 JAN 15 FEB
COMPLIMENTS	2	3	0	0
PHONE	2	110	44	43
PHONE UNKN CLIN			32	17
APPT	4	1	19	25
POLICIES	3	14	5	7
ASST/INFO	21	40	22	52
ATTITUDE	0	8	1	1
QUALITY CARE	0	8	2	6

COMPARISON OF PATIENT ENCOUNTERS POST PRIMARY CARE REORGANIZATION

CLINIC	COMPLIMENT	PHONES	POLICY	ASST/INFO	ATTITUDE	QUALITY CARE	APPT
<u>16 DEC - 15 JAN</u>							
RED	0	16	0	9	0	0	3
WHITE	0	10	2	6	0	1	8
BLUE	0	18	2	6	0	0	8
EC	0	0	1	1	1	1	0
CLINIC ?	0	32	0	0	0	0	0
TOTALS	0	76	5	22	1	2	19
<u>16 JAN - 15 FEB</u>							
RED	0	10	2	19	0	2	11
WHITE	0	11	3	9	0	2	7
BLUE	0	22	2	22	1	2	7
EC	0	0	0	2	0	0	0
CLINIC ?	0	17	0	0	0	0	0
TOTAL	0	60	7	52	1	6	25

PATIENT ENCOUNTER COMPARISON FOR PCC AND EC

(15NOV-15DEC93 / 16DEC93-15JAN94 / 16JAN94-15FEB94 / 16FEB94-15MAR94)

<u>CLINIC</u>	<u>COMPLI</u>	<u>PHONE</u>	<u>-POLICY</u>	<u>ASST/INFO</u>	<u>ATT</u>	<u>QU CARE</u>	<u>APPT</u>
ED	1/0/0/0	30/16/10/22	5/0/2/4	14/9/19/11	0/0/0/2	1/0/2/1	0/3/11/3
HITE	1/0/0/0	23/10/11/6	5/2/3/1	10/6/9/8	3/0/0/2	0/1/2/1	0/8/7/12
LUE	1/0/0/0	57/18/22/15	3/2/2/0	16/6/22/10	0/0/1/2	2/0/2/0	1/8/7/3
?	0/0/0/0	0/0/0/0	1/1/0/3	0/1/2/5	5/1/0/2	5/1/0/1	0/0/0/0
PH(?)		0/32/17/18					

repared 28Mar94/pb

Phone Complaints - Clinic not identified.

Primary Care Health Clinic

Red

White

Blue

and

Silver

Blanchfield Army Community Hospital
Fort Campbell, Kentucky

MEDICAL NUMBERS

CLINIC APPOINTMENT NUMBER	798-
Clinic Telephone Advice Nurse	798-
Appointment Cancellation Number	798-VOID
CHAMPUS/Health Benefits Advisor/	
Health Care Finders	798-8280
Patient Representative	798-8091
Patient Information	798-8388
Hospital Operator	798-8400
Emergency Center	798-8000
Amulance:	
On Post	798-6111
Clarksville/Montgomery County	911
Oak Grove/Christian County	886-9111
Hopkinsville	911

SCHOOL PHYSICALS

Blanchfield Army Community Hospital at Fort Campbell schedules school physicals Monday through Friday all year. To schedule appointments call 798-8885 between 0700 and 1500. Appointments will be scheduled between 1230 and 1530. The necessary school forms are available at the hospital. Children are asked to wear baggy or simple to remove clothing. Only children being seen should be brought to the hospital.

The Fort Campbell School system requires a physical for:

1. Preschool-Kindergarten or first grade students entering the school system for the first time,
2. Students transferring from another school system,
3. All Students entering sixth grade even if they were in the Fort Campbell schools in the fifth grade,
4. Sports physicals are also required before participating in any sport activity.

The Kentucky-Christian County School system requires:

1. Students entering the Christian County School System for the first time,
2. Kindergartners,
3. Students entering the sixth grade,
4. Sports physicals are also required for students that will participate in athletic programs.

The Clarksville-Montgomery County School system requires:

1. Kindergarten or first grade students entering the school system for the first time,
2. Any student transferring into the system,
3. Sports physicals are required for students that intend to participate in school sports.

Each school system requires that the physical and immunization records be reported on their form. Blanchfield Army Community Hospital has the required forms for the school systems in this area. Kentucky requires all students enrolling for the first time to have a TB test result form and a Kentucky Immunization Certificate and Tennessee requires the Permanent Tennessee Certificate of Immunization be submitted.

WELCOME TO THE RED, WHITE, & BLUE & SILVER!

Blanchfield Army Community Hospital joined the Department of the Army's Gateway to Care program in October of 1991. As one of the thirteen pilot sites, we have worked to find the best method of providing quality health care while containing the growing cost of medicine.

Through the Gateway to Care program we have enlarged the pharmacy, purchased new diagnostic equipment, expanded the Same Day Surgery options, increased hospital parking, added telephone health care advice nurses and dozens of other behind the scene improvements to better serve our patients.

Our current initiative will revamp our organization to provide primary care clinics to our beneficiaries. This will provide a "family practice" type of health care to the family members of every unit at Fort Campbell and to many of our retirees and their family members. The benefits of primary care clinics include continuity of care by a medical staff that has the opportunity to know their patients, peace of mind in knowing who to call for care or just to ask questions about your health care; knowing you have a "gatekeeper" to ensure your family receives appropriate preventive care such as immunizations; and having someone who will remind you of educational classes available such as smoking cessation, weight loss clinics or cholesterol control. The primary care clinics will provide comprehensive health care, including pediatrics, well/baby exams, immunizations, prenatal care, gynecologic and obstetric and all other adult medicine. Each of the new clinics will have family physicians, pediatricians, general medical officers, physician assistants, nurse practitioners, a telephone health care advice nurse and administrative staff.

The patients currently in Family Practice will join the clinic where their primary care physician has been assigned. There may be cases when this is not possible, but where possible it will be done.

Our active duty service members will still receive care at their assigned Troop Medical Clinic (TMC).

The new clinics will be formed from the current Family Practice Clinic, the Pediatric Clinic and part of the OB/GYN clinic. The new Red, White, Blue and Silver Clinics should be operational in early FY 94; our goal is 1 October 1993.

WHO GOES WHERE?

Each of the four clinics will have a set patient load with the assigned units determining which clinic will be used. The only exception to this is the Silver Clinic that provides care for many of our retirees and their family members. Retirees and retiree family members currently in the Family Practice Clinic will follow their current physician to the new clinic.

RED CLINIC will provide primary care for the family members of:

1st BDE
160th Special Operations Avn Regt
101 Support Group Corps
326th Engineer
501st Signal
MEDDAC/DENTAC
Information Systems Cmd
529th Engineer
535th Engineer
Retirees and Retiree Families

BLUE CLINIC will provide primary care for the family members of:

2d Bde
DISCOM
DIVARTY
2/44 Air Defense Artillery
HHC Division
311th Military Intelligence
MEDDAC/DENTAC
902d Military Intelligence
Retiree and Retiree Families

WHITE CLINIC will provide primary care for the family members of:

3d BDE
Aviation BDE
5th Special Forces Group
Law Enforcement Cmd
MEDDAC/DENTAC
Criminal Investigation Division
1/58 Aviation BN
Trial Defense
Retired and Retiree Families

SILVER CLINIC will provide primary care for retiree and retiree family members that have been previously seen in Internal Medicine or Outpatient Clinic, or have special needs.

do not want or need to come into the hospital.

If a home remedy will provide the necessary relief, you'll be given instructions on exactly what to do. If, however, you and the nurse determine you need to be seen by a doctor, you'll be given an appointment within a time period appropriate to your symptoms and health history. If necessary, there always is a physician available to consult with the nurse.

If, while talking to you, the nurse needs to check your medical record or consult with your physician, you will be asked for your phone number so you can be called back. You can rest assured that you will be called promptly.

Not only will the information you provide be used to give you advice, it will be recorded and added to your medical record. This means your doctor has a permanent record of your condition, symptoms and recommendations you were given.

Our telephone health care advisor network is a very important part of providing care for our Gateway to Care members. We want to provide the best health service possible in the most efficient manner.

An update on telephone numbers and clinic areas will be provided in the near future.

IMMUNIZATIONS

For people needing immunizations the Immunization Clinic will give shots during the following hours:

Tuesday	1230 to 1600 hours
Wednesday	0730 to 1100 hours and 1230 to 1600 hours
Friday	1230 to 1500 hours

Medical and Shot records must be brought to the appointment.

All dependents under eighteen years of age must be accompanied by a parent. There is a 20 minute waiting period after routine immunizations. Remember, only the child being seen should be brought to the clinic.

THE TELEPHONE NURSE

TELEPHONE HEALTH CARE ADVISOR NETWORK

Another benefit to belonging to the Primary Care, Red, White and Blue Clinics is the Telephone Health Care Advisor Network. These registered nurses are trained to help you determine if you can handle a minor illness or medical problem at home, or if you need to see a health care provider.

Sometimes you don't feel well and you don't know exactly what to do. Maybe your stomach hurts or you have a sore throat and a cough. These are the times you ask yourself "Do I need to visit the doctor to be checked? Should I go directly to the emergency room? Could I just take an over-the-counter medicine and stay home to rest?"

So, in addition to feeling sick, you're worried about how to get better. As a member of the Red, White and Blue Clinics you always have an expert available to help answer your questions and alleviate your worry. Blanchfield is now staffed with specially trained, registered professional nurses who can advise you on the best way to deal with your health and illness conditions. They are called Telephone Health Care Advisors or telephone nurses. The telephone nurse, using guidelines established with your doctor, provide health information and advice based on the nature and severity of your condition.

To be most helpful, the telephone nurse will need to obtain some basic information. As always, you'll be asked for your name and sponsor's social security number and current military status or the same information of the family member for whom you are calling.

You will be also asked detailed questions about your specific concern or symptoms. Once the telephone nurse understands the nature of your illness, you will be asked about your health history. It is important to learn if you have diabetes, high blood pressure, heart or lung diseases or other chronic health conditions. It will be important to know if you take any medications on a regular basis. You might find it helpful to have your medication bottles handy when you call.

Armed with all of this information, the nurse will be able to evaluate and provide you with a recommendation. One of the most important functions of the telephone nurse is to be able to assist you at home if you

HOW DO I ENROLL?

That's as easy as keeping your appointment! When you call for an appointment after the new clinics open, the appointment clerks will schedule you with the appropriate clinic, based on your unit assignment. When you come to that appointment, you will be asked to complete a registration application. It will ask for the sponsor's name, social security number, and family information, such as the number, names and ages of children, and birth dates of family members; and any health insurance the family may have.

Information about health insurance is important to both the hospital and you. It is now a law that military medical treatment facilities file insurance claims to reimburse the government when possible. Individuals will not be billed for the cost of medical care. Any portion of the bill not paid by the insurance company will not be collected. Individuals not having insurance will not be billed for any of the care.

In order to comply with this federal law and to collect your benefits, we must have the information that appears on your insurance card.

66T

★ How about references?

APPOINTMENTS

Each clinic will have?????

PRESCRIPTION SERVICE

For prescriptions the hospital pharmacy is open Monday through Friday from 0730 to 1800. It is also open on Saturdays to handle prescriptions from the Emergency Room or from the Outpatient or Pediatric Clinic appointments. It is not staffed to handle routine refills on Saturdays. The Refill Pharmacy at the Post Exchange is open Monday through Friday from 0900 to 1700. Both are closed on holidays. There is a call-in refill service from 1330 to 1530 Monday through Friday for next work day pickup after 1330.

The Self-help counter for over the counter medications is open the same hours as the pharmacy. After 1800 these medications are available in the Outpatient Clinic until 1100.

FOR YOUR ASSISTANCE

The Coordinated Care Division is located in Building 2530 at Indiana Avenue and 23rd Street. That is directly behind the hospital. The CHAMPUS advisors, case manager, health care finders and health benefits advisors are located at this location. The Health Benefits Advisors and Health Care Finders will help you understand your health care options. They will assist you in locating a CHAMPUS Select, CHAMPUS, or MEDICARE provider in your area. The case manager will assist you with monitoring and managing long term health care needs. The telephone numbers remained the same. The CHAMPUS number is 798-8280.

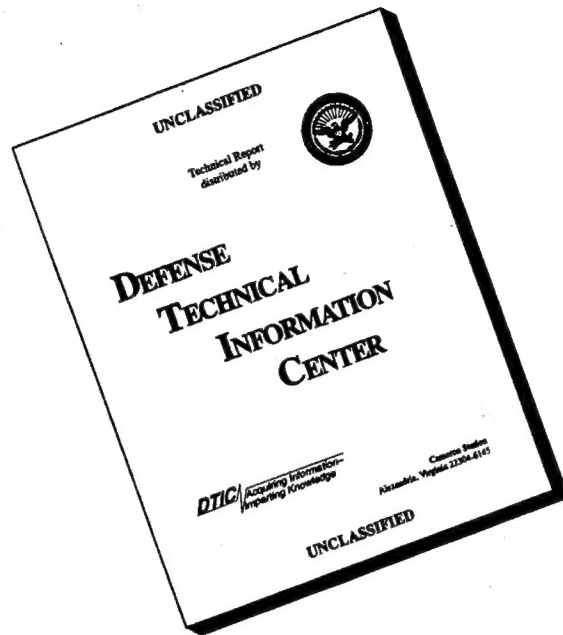
HAVE A PROBLEM?

Blanchfield Army Community Hospital has two full time patient representatives to assist beneficiaries. Anyone that has a concern or suggestion about the service or staff are asked to first contact the Non-commissioned Officer In Charge (NCOIC) of the clinic or office they wish to discuss. If they feel the issue was not addressed adequately, they should then contact the Patient Representative's Office. This office will remain at the same location in "C" Building (room 2CU01 and 2CU03). Their telephone number is 798-8091.

EMERGENCY NUMBERS

For emergency medical service on post (ambulance) call 798-6111. If that number is busy, the backup number is 431-4677. Off post ambulance service is available for Hopkinsville (within the city limits) by calling 911 and for Christian County (outside of the Hopkinsville city limits) and the Oak Grove area by calling 886-9111. For Montgomery County (Clarksville area) ambulance service call 648-5735 or 911. Requests for ambulance service off post must be referred to the responsible county's Emergency Medical Service. The county will contact Blanchfield Army Community Hospital if they need assistance.

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